Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

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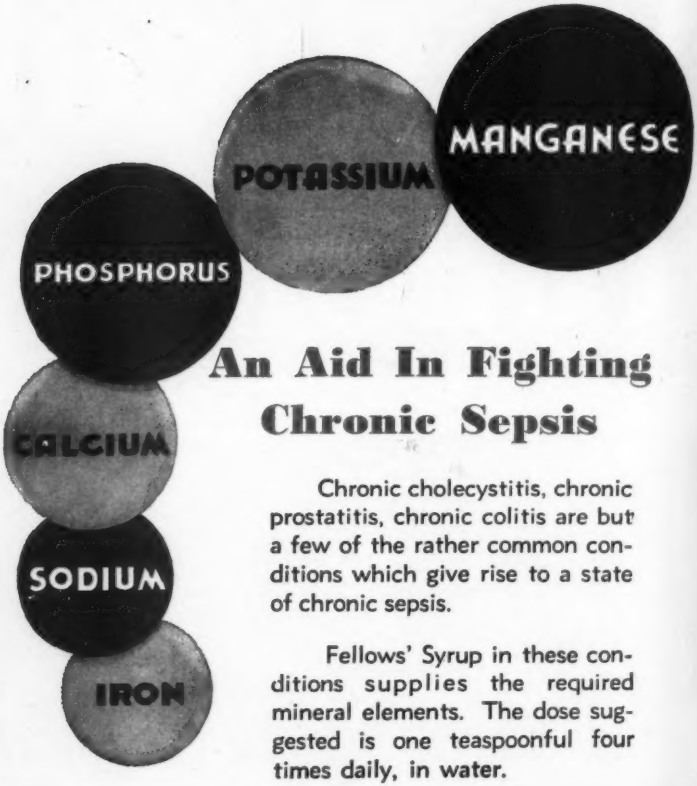

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MEDICAL ECONOMICS

The Business Magazine of the Medical Profession

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In the interests of the profession, MEDICAL ECONOMICS requests that its readers kindly fill out and mail immediately the questionnaire card facing page 16.

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They stopped the mail to save a life

DECEMBER 23rd, 1931. One hundred thousand people in a Western city were mailing and receiving Christmas packages. Postal clerks worked frantically at their annual miracle—getting the mail through on time. Suddenly they stopped their systematic sorting. Let the mail pile up — dropped it and left it there while they set out to find one small package in four carloads just arrived from a distant city.

In all the mountains of Christmas packages that one alone held the promise of life for a certain young man with death at his bedside. It contained pneumococcic serum ordered by wire and mailed the day before—but mislaid among the thousands of Yuletide remembrances. For three hours death stooped low over the sorting rooms while twelve veteran clerks went through a thousand cubic feet of packages one by one, found the precious serum in next to the last sack in the pile. Rushed it to the hospital in time to continue the battle for life that might otherwise have been lost by Christmas eve.

On land as well as sea the saving of human life takes precedence over all else. Yet a few years ago it would have been futile to search the mails for an antibody solution capable of holding pneumonia in check. But each year sees the physician better equipped with agents supplied by bacteriologists and chemists to help him combat the inroads of micro-organisms. Among these is Zonite, that provides dependable germicidal action whenever it is required upon the skin or accessible membranes of the human body.

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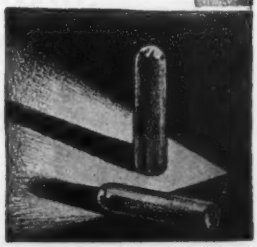

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SPEAKING FRANKLY

Embryo TO THE EDITOR: I would appreciate greatly your sending me the complete schedule of average, minimum fees, compiled from the MEDICAL ECONOMICS survey which was mentioned in the October issue of your journal. Very few medical schools teach the student anything about fees. Hence, for a young embryo physician cast upon the mercy of older colleagues, such a schedule as you offer listing 600 operations and treatments, would be invaluable.

G. L. Rothenmaier, M.D.
Elkhart Lake, Wisconsin

Annuities TO THE EDITOR: Several recent copies of MEDICAL ECONOMICS have come to my attention. I have had the distinct pleasure of reading in them three splendid articles which touched upon the merits of life insurance and annuities. The writers of each should be highly complimented on their intimate knowledge of the principles of life insurance and its value in the investment program of the practicing doctor.

A. D. Hallagan
Metropolitan Life Insurance Co.

Pioneers TO THE EDITOR: It is certainly a great pleasure to write to you again on the occasion of the tenth birthday of "our" magazine.

I want to congratulate MEDICAL ECONOMICS and all those who together have contributed to its success.

It has reached an important place as a help to the medical profession; and its words are certainly recognized as authoritative.

I met MEDICAL ECONOMICS only two years ago. But through these months, I have profited by reading its wise editorials and stimulating articles.

At this time, therefore, I want to express my great admiration to the magazine for its educational and pioneering work in this phase of medicine.

Juan Basora Defillo, M.D.
Mayaguez, Puerto Rico

Ten TO THE EDITOR: Best congratulations and future success on the tenth anniversary of MEDICAL ECONOMICS. A publication like MEDICAL ECONOMICS must continue and will continue as an outstanding volume among the medical profession.

F. H. Felgoise, M.D.
Philadelphia, Pennsylvania

Sensers TO THE EDITOR: I value MEDICAL ECONOMICS highly. Your editors seem to be two or three laps ahead of general medical opinion. They sense the changes, and are always ready with advice to meet them as they arrive.

More power to you!

H. P. Frost, M. D.
Worcester, Massachusetts

Dawn TO THE EDITOR: Your unique magazine is rendering a most valuable and timely service to the medical profession. I know that if every one of your thousands of readers is actually assimilating it and thinking about the situation confronting UNorganized medicine at this time, the dawn of a brighter and better day can not be far off. Hence, more power to you!

Oscar F. Baerens, M.D.
St. Louis, Missouri

Dentists TO THE EDITOR: We younger men in the profession realize the acute lack of cooperation between dentists and doctors, as suggested by Dentist Falk in October MEDICAL ECONOMICS.

Educational pamphlets issued by a cooperating editorial board of dentists and doctors would certainly be welcome. The idea could also be augmented by joint society meetings where animosities might be aired face to face.

E. H. Blair, M.D.
Chicago, Illinois

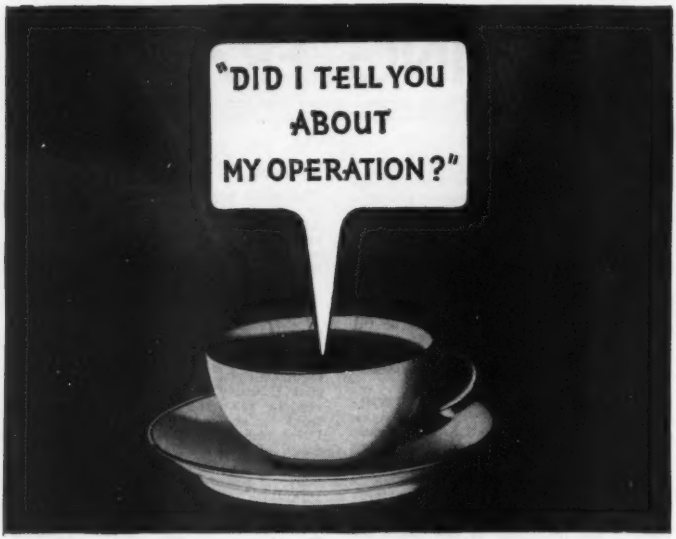
Loyal TO THE EDITOR: I have been receiving MEDICAL ECONOMICS for a number of years, and have never missed reading a copy that came to my desk. I have been pleased to find—as have many others, no doubt—that most of our economic problems are being revealed and reported on in a highly intelligent way. I invariably try to favor those firms that advertise in MEDICAL ECONOMICS.

William F. Roney, M.D.
Medford, Oregon

Orchids TO THE EDITOR: Congratulations, orchids, a bit of a pat on the back, a fraternal squeeze of the hand, and may MEDICAL ECONOMICS' shadow continue to lengthen!

Ten years of useful service. . .I salute!

Oscar F. Baerens, M.D.
St. Louis, Missouri



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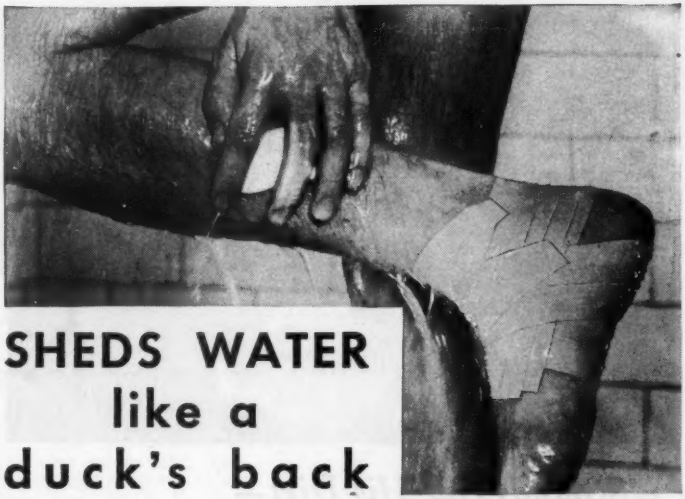

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MEDICAL ECONOMICS
The Business Magazine of the Medical Profession

Nativity

A true Christmas story in which a young doctor and a backwoods baby come to life simultaneously

By CLAY EVATT, M.D.

"DOCTOR, you look powerful young to be deliverin' babies," old Mrs. Ledbetter observed.

Halbert F. Rhodes, third year medical student doing relief duty practice at the coal mines and lumbering camps forty miles from nowhere in the mountains, interrupted his reverie to answer her.

"Yes, I suppose I do look young," he admitted, with a smile, "but I'm really much older than you think, and I have attended any number of cases. Some of them were abnormal, too. But I'm sure Mrs. Hendrickson is going to get along just fine."

He made a mental grimace as he called to mind the stark, unadorned truth that actually he had witnessed but *one* delivery—and that a perfectly normal one. But he was chuck-full of the theory of obstetrics, at any rate!

He lapsed into reverie again, as the clock struck three. Three o'clock—no longer Christmas Eve, but Christmas Day! Hal's thoughts raced across space to the distant city where his sweetheart was spending the holidays. To-night, he told himself, jealousy gnawing at his vitals, she'll be having a gay time dancing—dancing with some other fellow.

"Oh, Doctor!" the woman on the bed called to him, "how much longer will it be now?"

"Not long. You're coming along fine, Mrs. Hendrickson. Just take it easy."

Nonchalantly the young doctor-by-courtesy stroked his infant mustache. It helped him, he fondly imagined, to present the appearance of maturity and soberness essential to a doctor just beginning to meet the public.

He recalled the conclusion of some of the boys at the University: To attract the right sort of attention, the young doctor must walk with dignity, drive in a hurry, and smoke big cigars. No doubt his carefully-waxed mustache made the assembled grannies credit him with more years than he could rightfully claim.

All through the night he talked and joked with them, calling upon what he hoped seemed like an inexhaustible store of reminiscence to impress upon them that he was a man of no little experience. At least, his amiable chatter kept the conversation off the embarrassing subject of his youthfulness.

•

"Say, I was shocked the other day," he said. "Down at the club house they told me that the two men detailed to bury old Frank Posey struck rock in his grave; and, with a snowstorm coming up, they put the coffin in the tool house and drove on back to town. It seems rather disrespectful of the dead."

"Huh, why be surprised at that, Doctor?" Mrs. Ledbetter chimed in. "You said they wasn't nobody went nigh to nurse him when he was sick with pneumony fever before he died. You couldn't expect the same crowd to do any better by him after he was dead could you?"

•

Except for the white shirt and the necktie he wore in place of the usual red-and-black lumberjack shirt, Hal was dressed much the same as the native bosses. Early in the evening he had taken off his knee-high boots and his sheep-skin coat. They lay piled in a corner, with them one of his proudest possessions, a German automatic—all the substantial citizens of the district, he reflected with satisfaction, carried either a Luger or a Smith & Wesson.

Three o'clock in the morning .... Joan's asleep now, I suppose .... maybe she'll be dancing this time tomorrow morning .... with what sort of chap? .... Wonder if this is going to be a normal case? .... Oh, Lord, if I run into the kind of thing Doctor Evans was telling us about! .... Between three and dawn everything's at low ebb, they say .... even the birds, the trees, the very wind, are hushed and lulled then ....

Spasmodically he now sat in the split-bottom rocker and then paced the floor, trying to gain the confidence of his audience and generate assurance within himself. He matched every hard luck story of the grannies by a funny one, hoping above all to keep up his patient's courage, and impress upon her that, though short in years, he was long in experience and equal to any emergency.

The half-dozen old women, relaxed after their midnight supper, dozed in their chairs and gathered rest against the time when their all-night vigil would be over. Even Mrs. Hendrickson, her suffering temporarily abated, dozed off.

Presently Mrs. Yates opened heavy eyelids and shook off her

[*Continued on page* 99]

This view shows a group of postgraduate medical students —several of them Americans — after leaving a class at the University of Paris.

PARIS for the Postgraduate

By DONALD B. HULL, M.D.

PARIS is well on its way toward becoming the leading medical center of Europe. Both in my opinion and in the opinion of physicians who have taken postgraduate work all over the Continent, Paris offers more up-to-date medical equipment and a greater supply of interesting clinical material than any other city, including Vienna.

Of all European countries today, France is perhaps the most stable, financially and politically. As a result, ample funds are made available by the government to renovate and modernize the older hospitals and to construct new ones.

At the present time a large new medical center is being built in Paris, and a studious younger generation of physicians and scientists is taking the place of such illustrious figures in French medical history as Pasteur, Tarner, Charcot, and Courvoisier.

Surely France has much to offer the American physician considering postgraduate work abroad. When should one go and approximately what will it cost him? These are the questions which, from my own recent experience, I shall undertake to answer.

Finding myself in accord with the doctor who, writing in MEDICAL ECONOMICS some months ago, suggested that a time of economic depression offers an excellent opportunity to take postgraduate work and thus prepare oneself for the good business of the future, I determined on Paris, and

[*Continued on page* 78]

ANESTHESIA BECKONS

By F. H. McMECHAN, Secretary-General
International Anesthesia Research Society

THERE is a perverse streak in human nature, it would seem, which leads us to create something only to tear it down.

We create an organized medical profession, for example—and then we introduce the technician to compete with us economically.

The plain fact is that it is impossible to have an economically self-sustaining profession if it is to be put into competition with technicians.

Expert professional anesthesia *versus* nursing anesthesia is one of the most striking cases in point. Here a choice must be made, and *is* being made. The public, the hospitals, and the medical profession must decide which of the two, the technician or the doctor, shall be the anesthetist.

Though for years the hospitals have been exploiting their nurse anesthetists and trying to crowd the medical man out of the field, there now is positive evidence of a swing in the other direction. Nurse anesthesia has reached its peak, and is on the wane.

Expert professional anesthesia is definitely a coming, steadily developing medical specialty—which is as it should be. For on every count, not the least of which is the broad economic consideration, medical anesthesia is infinitely superior to nursing anesthesia.

The nurse anesthetist is distinctly uneconomical because in the first place, she constitutes a type of constantly shifting, vanishing personnel. As such she represents a prohibitive overhead to all concerned. We have gone along for years imagining that nursing was one of the profitable elements in our medical setup. On the contrary, it is one of the most serious sources of deficits.

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Excessive personnel turnover is largely the explanation. Dr. Stanton of the Schenectady General Hospital has determined that nurses, requiring three years to train, vanish at the rate of 50 per cent in the first two years, and 85 per cent within five years. Nurses who give anesthetics are no more permanent, by and large, than nurses who do nursing.

One indication of this fact is that nurses who have subscribed to journals of anesthesia have seldom remained subscribers for more than two years. In most instances they have changed their places of work once or twice during the first year, and then vanished. Apparatus manufacturers will tell you that they are constantly being called upon to train new nurse anesthetists about every six months, in order to keep their equipment sold.

Would industry temporize with such a situation? Can you imagine an automobile manufacturer, for instance, taking three

years to train his skilled personnel, only to see it vanish at the rate of 50 per cent in two years and 85 per cent in five? Certainly not. For industry knows that when a person has been trained over a period of years to perform a specific task, he represents a value of some thousands of dollars, since it will cost that much to train the person who replaces him.

Recognizing the costly instability of female personnel, the Cunard Steamship Company some time ago discharged all its women employees at its London offices, adopting the policy of an exclusively male personnel, and hiring only qualified young men who desired to enter upon shipping as a career.

In sharp contrast to the shifting and vanishing nurse anesthetist is the professional M.D. anesthetist. Instead of drifting from one hospital to another, he is a permanent staff member. In other words, he stays put.

The doctor who goes into anesthesia as a specialty stays in anesthesia, as a rule, and is good for a lifetime of service, increasing in value with the years of experience and study. The loss of highly-trained personnel here is virtually negligible.

For thirty years I have been in intimate touch with organized anesthesia, and I can count on the fingers of my two hands those doctors who have left the specialty. Furthermore, these men have not been lost to the practice of medicine, for they have abandoned anesthesia only to enter some other specialty.

Aside from the fact that the rate of personnel turnover among nurse anesthetists is excessively high, it is easily demonstrated that, by comparison with expert medical anesthetists, these technicians are startlingly unprofitable to the hospitals that employ them.

Hospitals imagine that they are making money by paying tech-

[*Continued on page* 87]

How Much Charity

ANY doctor of medicine who merits the title is willing to donate a reasonable portion of his time to charity service. Helping the needy poor is not only an obligation but a tradition inseparably associated with medicine since its earliest history.

On the other hand, there is a difference between reasonable and exorbitant demands. There is a definite limit to the amount of gratuitous treatment the practitioner can and should be expected to give. When this limit is exceeded and he feels he is being imposed upon, he very rightly takes offense.

With the demands for free service becoming louder and more insistent at the present time, this feeling of natural resentment stirred up among physicians is fast approaching open indignation, perhaps rebellion, against a situation so obviously unfair and discriminatory.

MEDICAL ECONOMICS believes with a great many men in the profession that the obligation for the bulk of charity services—especially since the demand has grown to such impossible proportions—should rest with the municipalities, the counties, the States, and the Government—not with the individual practitioner.

•

Granted that it is unreasonable to expect the medical profession to bear the burden of treating the sick poor, what can we do about it?

One answer lies in influencing public opinion to recognize our side of the story.

With hospitals and clinics setting the style, the rank and file of the people have grown to expect practically unlimited free and cut-rate services from private physicians.

"The doctor said if I would keep on coming to the clinic he would keep me well enough to hold my job."

—By Wortman © United Feature Synd.

"Pay everyone but the doctor; he doesn't expect it"—this represents the consensus of lay opinion in many quarters.

Mulling the situation over among ourselves, no matter how explosive we get, accomplishes little.

What we must do is to assemble our facts, prepare our case, then smash it home *to the public* with everything we've got, so that there won't be a man or woman as time goes on, who will *expect* to receive undue free service from the medical profession, except in isolated and emergency cases.

Having chosen the lay public as our target, how are we to direct our message?

One means is to focus national attention on the tremendous abuses inherent in present-day charity.

To this end, MEDICAL ECONOMICS proposes to lend its entire support. As its first step in

WITHOUT SIGNING THIS CARD or identifying myself in any way, I submit the following reasonably accurate estimates concerning my practice:

1. I work.....hours a week.

2. I work.....weeks a year.

3. I devote.....hours a week to charity work.

4. (Optional question) My annual net income is $.....

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BUSINESS REPLY CARD
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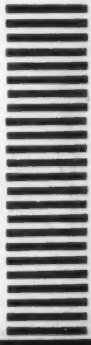
Medical Economics,
Rutherford, New Jersey

The Editor



Work Do You Do?

this direction, it is employing the questionnaire card that faces this page. Here is the idea behind it:

Through the cooperation of several thousand physicians in supplying the information requested on the card, MEDICAL ECONOMICS is going to be able to do something which it believes has never been done before, namely: to estimate with some real degree of accuracy the dollars-and-cents value of charity service contributed to the public by the entire American medical profession each year.

Since it is already known from past surveys what the average M.D.'s income is, it will be only a matter of simple arithmetic to find out what his services are worth per hour, and, hence, what the monetary value of all charity service rendered by the profession amounts to in a single year.

Whether the resultant figure will be in the millions of dollars, or whether it reaches the billion mark, one thing is certain: It will come as an amazing revelation to the public at large; and, properly publicized, it will make them realize consciously, for the first time perhaps, what a tremendous volume of free service American doctors are contributing to the sick poor of this country, what an imposition on the physician's time and income this has become, how demands for charity are growing by leaps and bounds every day, and that it is high time for everyone concerned to recognize that the financial responsibility for providing medical treatment to the indigent should rest with the local, State, and Federal authorities—not with the medical profession.

Individual practitioners are willing enough to contribute a reasonable portion of their time to the care of the poor, but they are convinced that under such heavy pressure as now exists, the relief agencies, the hospitals, and the clinics should also do their part—not by offering to treat the poor and then expecting private physicians to do the work for them without compensation, but by making medical care of the indigent available with the understanding that the doctor whose services make this work possible should and will be paid just as readily as the manufacturer or dealer who supplies the pharmaceuticals and clinical equipment employed.

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In filling out the card, please be as accurate as possible. If you do not know the exact answers, give reasonably correct estimates.

Question 4 is optional, but inasmuch as no names or addresses are to be given and there is no means or intention of identifying any of the thousands of cards that will be returned, you need have no hesitancy about being frank.

Results of the survey will be published in MEDICAL ECONOMICS simultaneously as they are released to the press.

Simply jot down your replies, and drop the questionnaire card in the nearest mail box NOW. No postage is required.

TO OUR READERS:

The questionnaire postcard facing this page represents YOUR opportunity to do something tangible in the way of combating charity abuse.

Will you please fill out the card and mail it NOW!

What the Detroit Plan

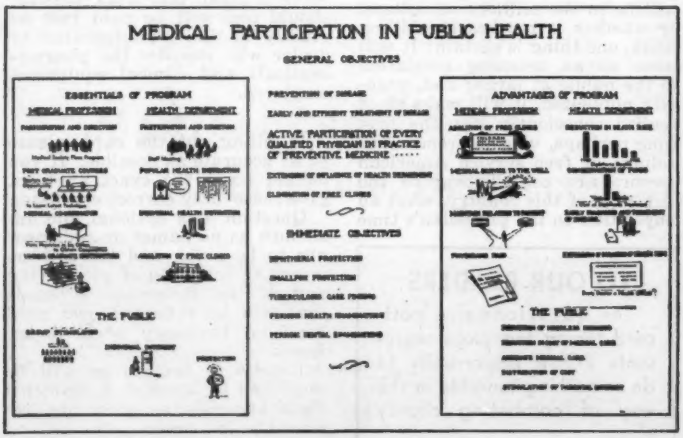
By HENRY F. VAUGHN, Dr.P.H.
Health Commissioner of Detroit
and
LEDRU O. GEIB, M.D., Public Health Committee, Wayne County Medical Society.

VIRTUALLY every qualified physician in Detroit has become, to all intents and purposes, a deputy health commissioner, and his office a center for preventive medicine. This is a direct result of the Detroit plan of medical participation in public health work.

The ultimate objective of the plan is to have the family doctor take care of his patients in health as well as in time of illness. Another objective is to re-educate the public to look to the physician in private practice for such preventive services as diphtheria protection, smallpox vaccination, and periodic health examinations, rather than to depend upon public agencies and free clinics—in short, to impress upon the public mind the fact that preventive medicine is a purchasable thing, and something that is to be paid for in the same manner as any other desirable commodity.

There are many public health administrators who feel that certain medical services which in the past have been provided by health organizations, both official and non-official, should be gradually transferred to the physician in his own office. They believe that such a program will broaden the influence of the health organization, will multiply the opportunities for health education, and will result in the conservation of both life and money.

The office of every prepared



Here in graphic form are shown the advantages and the organization plan of the Detroit system.

Offers

Are you anxious to improve the health of your community . . . extend your practice in preventive work . . . minimize the number of free clinics . . . secure the advantages of an ethical, large-scale publicity program . . . and at the same time be paid out of taxes for all services you contribute to the poor?

For six years Detroit physicians have been quietly developing a plan that would make possible these very advantages. Now that it has reached maturity and proven its merit beyond question, MEDICAL ECONOMICS publishes in these pages for the first time the complete story of its organization and operation.

physician should, in fact, become a health center from which will be dispensed not only knowledge regarding the prevention of disease but service, which, under any circumstances, is available only at the hands of the qualified physician. A community has only one health officer, but there may be thousands of practicing physicians, each one of whom should become an agent or deputy of the health department.

The Detroit Plan is expected to bring about a gradual elimination of free clinics, while at the same time assuring to the public adequate preventive medical service, regardless of the individual family's ability to pay, and likewise assuring to the doctor at least a nominal return for his services.

While it is true that the work which has been carried on in Detroit has become known in connection with the campaigns to prevent diphtheria, we wish to emphasize that this is not the principal objective of the program. *The real purpose is to secure the active participation of every*

Members of the Wayne County Medical Society planning the medical participation program. Dr. Geib heads the table.

qualified and prepared physician in the practice of preventive medicine.

When the plan was established some six years ago by a committee of the East Side Medical Society and later became a project of the Wayne County Medical Society, it was wisely determined that instead of endeavoring to transfer overnight all preventive medical services to the family or cooperating physician, we would begin with diphtheria protection. Such a program can readily be isolated from other preventive services, being an entity within itself.

The recent report of the Committee on the Costs of Medical Care affords to a certain extent, an opportunity to compare the so-called Detroit Plan with the recommendations of this Committee, although the Detroit enterprise was actually initiated a year before the Committee on the Costs of Medical Care was appointed.

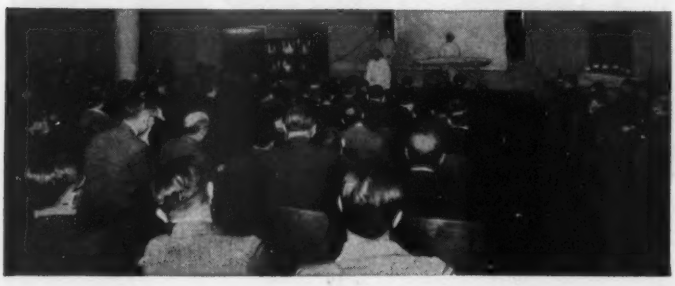
The Detroit Plan is a group plan—the group in this instance being the organized medical society (or the organized dental profession).

Contrary to the experience of socialized medicine in European countries, the medical profession becomes the organizer and leader in a program of the Detroit type. The group consists of all physicians in the community who are willing to lend their support to

[*Continued on page* 55]

For the second time, as the plaque above shows, Detroit has won first place in the Health Conservation Contest which the Chamber of Commerce of the United States has been sponsoring for the past four years.

In the photograph below a group of 300 physicians is seen attending a postgraduate conference on communicable diseases at the Herman Kiefer Hospital, Detroit.



MISCELLANEA

ALMOST ten million persons seek hospitalization annually in this country, states the Children's Bureau at Washington. Care to needy patients in United States hospitals, moreover, has increased almost four times in the past three years.

•

That physicians must unite for economic relief was emphasized by Dr. Kellogg Speed of Chicago at the recent five-day Omaha Mid-West Clinic Society meeting at Omaha, Nebraska. Dr. Speed and other speakers at the meeting rapped charity impositions, advocating immediate organization to overcome the possibility of further abuse. One plan suggested, which has already been described in MEDICAL ECONOMICS, involves a taking over by the county medical societies of all charity for the county, services so rendered to be paid for by county appropriations.

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A program for the certification of qualified medical specialists is expected to be completed by February, states Dr. W. T. Wherry, Omaha, Nebraska, secretary of a committee appointed by the A.M.A. to report on this subject.

Under the plan as now tentatively agreed upon, the prospective patient in any community will be aided in choosing his specialist by having available a list of those certified as being thoroughly competent to practice in each medical specialty.

According to Dr. Wherry, the program also provides for national examining boards in each specialty. These are to operate under a national advisory council. Certificates of competency, it is supposed, will be issued by the examining boards with the approval of the council.

So far as is now known, the advisory council will include representatives of each of the specialties, of the American College of Surgeons, the American Medical Association, and the National Organization of State Licensing Boards.

•

"The financial outlook for the professional classes under the NRA is not so rosy," observes Major A. H. Onthank, chief of the Control Division of the National Recovery Administration. "Professional incomes will be less quickly raised by better conditions than will those of other groups. John J. Consumer tends to put off that tonsil operation until he has a savings bank nest egg.

"The best thing that can happen for these professional groups is a quick restoration of additional purchasing power among the lower classes—exactly what the NRA is promoting. As net income improves, higher fees will result. The lag in professional incomes is a matter of history. It

In the interests of the profession MEDICAL ECONOMICS requests that its readers kindly fill out and mail immediately the prepaid questionnaire postcard facing page 16.

will probably repeat itself, except in a few cases."

•

Minimum fees agreed upon in 1880 by Dr. F. J. E. Tetreault and five confreres practicing in St. Paul d'Abbottsford, Canada, are revealed in a paper discovered recently by his daughter, Elizabeth T. Tetreault of Orange, New Jersey, and set forth by her in a letter to the *Newark Evening News*. Among the minimum prices the group promised to adhere to may be mentioned: extraction of a tooth, 25 cents; minor operation, 25 cents; vaccination, 25 cents; natural delivery, $3.

•

When a play about doctors is such superb theatre that blasé first-nighters and professional critics mention it for the consideration of the Pulitzer Prize Committee, and when it is at the same time (though the work of a layman playwright) remarkably free of the technical "boners" which have usually spoiled for the physician-playgoer dramas dealing with him and his profession, that play is worth recommending to doctors.

Such a one is *Men in White*, by Sidney Kingsley, produced by the Group Theatre at the Broadhurst, in New York City.

It might be subtitled "A Play In Praise of Doctors." Certainly it holds the profession before the general public in a most favorable manner. The spirit of dedication, of consecration, even, in which the medical man turns to his life work is admirably caught and mirrored in the nine scenes within the walls of a modern hospital.

Shall the young resident physician marry the girl whose father's wealth and influence can smooth his way to ease and affluence in practice? Or, forsaking all personal and family considerations, shall he follow the difficult path pointed out by the stern old specialist, a path leading to ultimate high achievement in medicine?

The way in which this situation resolves itself furnishes an evening of first-class entertainment—and hands a large and beautiful bouquet to us! If we used *Liberty's* recommendation system, we'd trot out a whole line of stars for *Men in White*.

•

Opposition to any form of licensing for the medical profession under an NRA code was voiced by Dr. Dean Lewis, president of the American Medical Association, and by Dr. E. H. Skinner of Kansas City, at the recent Mid-West Clinical Conference in Omaha, Nebraska.

[*Turn to page* 49]

An operating-room scene from "Men in White": interesting to the public and surprising to medical men by its accuracy of detail.

The Doctor and His Investments

MARKET EMOTIONALISM IS FATAL

MOST investors are dominated by the herd instinct. They follow the crowd. They do what others do because it is easier. It might even be added that some men go from the cradle to the grave without doing anything alone. All their lives they follow the crowd, with the mistaken idea that this represents the safest practice.

It may be the key to success in politics, but not in finance. There are always crowds in the investment markets—crowds of buyers and crowds of sellers. And when one enters a brokerage office or, in other words, the market, one usually joins the herd that is the biggest.

That is the first mistake. A walk through a brokerage office reveals this crowd psychology more effectively than could a library of books on the subject. It also reveals another equally insidious influence—gossip.

There is just as much gossip in a brokerage house as there is between the average janitor and housemaid. It is often circulated intentionally by those who appreciate the gullibility of the crowd.

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Obviously, then, the herd seldom deserves to be followed.

It might be accepted as a rule never to buy when there are more buyers than sellers. If the investor overlooks this, he is sure to pay too much.

In the same way, he should never sell when sellers are in the majority. If he does, he is sure to get too little. These are common-sense, practical axioms of investment success.

Buy when it is the fashion to sell, and sell when the crowd is buying. Remember there are always booms and depressions, and every reaction is followed by a rally.

•

The crowd, of course, never looks far enough ahead. Its thoughts are of the present. Most people are optimistic during a boom and pessimistic in times of depression. Why? Because, as stated before, it is easiest.

But *the investor who makes money*—and after all that's the reason anyone participates in the market—*is the man who buys from the pessimist and sells to the optimist.*

It is a fact that when prices are high, the crowd believes they will go still higher; and when they are low, it believes they will go still lower.

Prices are influenced by all the happenings and by all the hopes and fears of the world. They move above and below the line of true worth, but they seldom go out of sight in either direction. Usually the hopes and fears of the crowd are carried too far. As soon as temporary pressure is removed, prices swing back to their proper places.

That is why the investor should

not give in to this fatal herd instinct. That is why he should cease trailing the bellwether. *Instead, he should buy when stocks are low, and sell when the herd is grasping for them—at the top.*

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Doctors doubt Maher theory

Has Dr. Stephen J. Maher of Shelton, Connecticut, after 25 years' research, discovered a special type of bacteria that destroys the bacillus of tuberculosis—human, bovine, and avian?

Hard upon the heels of the public announcement of such a discovery comes a vigorous denial from other medical men. Consulting specialists of the New York Academy of Medicine issuing a joint statement, declare:

"There is nothing in the scientific world which at present warrants the belief that we are at last on the trail of a certain remedy for the great white plague. It is most imperative that those who are now in the process of curing themselves of tuberculosis should not abandon the routine of their treatment in the pursuit of an unestablished promise of quick cure."

Dr. Maurice Fishberg, head of the tuberculosis service at Montefiore Hospital, adds: "There is nothing new in it. It has no bearing on the future. Doctors have long been able to kill a host of the bacilli in test tubes, but this has put them no further ahead in killing the dreaded organism in the body."

Dr. Maher is shown above, standing before his incubator containing tubercular bacilli.

THE NEWSVANE

NO longer will President Roosevelt enjoy anything like clear sailing as he endeavors to pilot the Ship of State into the calm, safe waters of eventual economic recovery. The Administration has lived through its honeymoon stage. From now on life will be real, and equally earnest.

Opposition to his recovery plan becomes daily more apparent. It is rapidly becoming organized, and voices its disagreement with him in no uncertain terms.

There are many indications that the Administration is definitely on the defensive, impatient of criticism in the matter of its monetary policy especially. There is even a hint now and then of dictatorial censorship of the news from Washington.

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The resignations of Dr. Oliver M. W. Sprague, financial and executive assistant to the Secretary of the Treasury, and of Dean Acheson, Under-Secretary of the Treasury, in the month just past have been widely commented upon as significant straws in the wind.

They are but part of a rising tide of uncertainty as to what all the turmoil is about, and growing doubt that the generals are properly conducting our warfare against the forces of economic distress. They indicate not so much discontent with what has happened to our monetary system as apprehension of what *may* happen if present tendencies are carried through. The big, bad wolf is, of course, inflation.

Possible monetization of silver, the Government's gold policy, the devaluation of the dollar—these are things which have continued to loom in recent days' news.

The country which seemed so heartily back of President Roosevelt in March finds itself, figuratively, divided into two hostile camps today. Gold policy is the sore spot. The President has his supporters, of course; but defections from the ranks of the faithful become increasingly numerous.

•

A considerable ripple of interest was apparent across a country grown used to almost constant discussion of monetary policies in the daily press when Al Smith recently came out point-blank against the President's gold program.

Kicking over the traces with a gesture that made the front page nearly everywhere, the Happy Warrior declared himself unequivocally for a gold dollar as opposed to a "baloney dollar."

President Roosevelt has thus far ignored the attack. Not so his ardent supporters. Father Coughlin, fire-eating priest whose vigorous proclamations on things economic, social, and governmental assail the ether waves from his broadcasting station at Royal Oak, Michigan, springs to the defense.

A throng of 6,000, gathered in New York's Hippodrome a few nights ago heard Father Coughlin's impassioned championing of President Roosevelt's gold policy, cheered his demand that the

President "be stopped from being stopped."

On the very same night another mass meeting was held in the city by those who believe with John Maynard Keynes that at the moment this country is like "a powerful airplane, completely out of control and headed for a forced landing we know not where." The Crusaders, allied with the American Federation of Labor and the American Legion, held their rally in Carnegie Hall in an effort to stave off inflation. Those assembled heard Matthew Woll, vice-president of the A.F.L., bitterly assail the Administration's monetary policy.

Woll called upon the President to "no longer allow the alarm to spread that a policy of uncontrolled and uncontrollable inflation is being inaugurated," and demanded that the Chief Executive tell the country where he is taking it.

Thirty-eight members of the faculty of Columbia University join to urge an "expeditious" return to the gold standard and suggest an international agreement to ward off a threatened major crisis in finance. And in Chicago 26 prominent business figures issue a manifesto against inflation.

•

Meanwhile, in Washington, officials are frankly worried over the matter of financing all the huge projects to which the government has definitely committed itself. They have not been so sober since those memorable days of last March.

Simultaneous with the Government's announcement of a big new make-work plan, undoubtedly meritorious but at the same time alarming to investors, Government bonds have suffered an abrupt drop. If they continue their downward stride, the analysts say, President Roosevelt will be forced to some new decisions: He must swing sharply to the right toward conservatism and sound money in order to reassure investors; or he must press on to immediate dollar depreciation and inflation.

And, say close observers, we are undeniably headed towards inflation.

•

Administration critics are in nothing like full agreement on what should replace the present monetary policy. Should we return at once to the old gold parity of $20.67 to the ounce? Relatively few have said so.

However, the opposition clearly asserts that the experimenting with the dollar has gone far enough, and that it must be stabilized at some point as high or higher than its present level, and that we must return to a gold basis as quickly as we can.

Says Professor Neil Carothers, of Lehigh University: "There is less excuse for inflation now than there was in March, and there was none then . . . If tomorrow it should be announced that this nation intends to go back to the gold standard at the valuation every preceding Administration has held sacred, recovery from depression would be assured."

There is no indication of fairly immediate stabilization of the dollar in any of the openly-announced or implied policies of the financial team of Roosevelt, Warren, and Morgenthau—whose ultimate aim evidently is the commodity dollar: a devalued gold dollar with a gold content fluctuating to keep prices stable.

Business, despite the welter of uncertainty in which it struggles, slightly improved in November, and a similar improvement is indicated for December. But it looks as though there can be no really heartening signs until alarmed capital is reassured that the Government's swing toward the left will eventually be diverted to the right—toward an orthodox monetary and business program.

We Were Right!

SEVEN years ago, in June 1926, to be exact, MEDICAL ECONOMICS asked 13,000 doctors whether they were satisfied with conditions resulting from the Volstead Act.

Of the 2,384 replies received, the consensus of opinion, as shown by 1,909 dissatisfied votes as against 475 satisfied, was that prohibition was a failure.

Typical of the comments of the majority answering the questionnaire are the following:

"I consider prohibition an unjustified personal restriction and a great failure morally, economically, and therapeutically."

"It is making a nation of hypocrites and law-breakers."

"Prohibition has caused more graft, theft, and murder than any other law on the statute books."

•

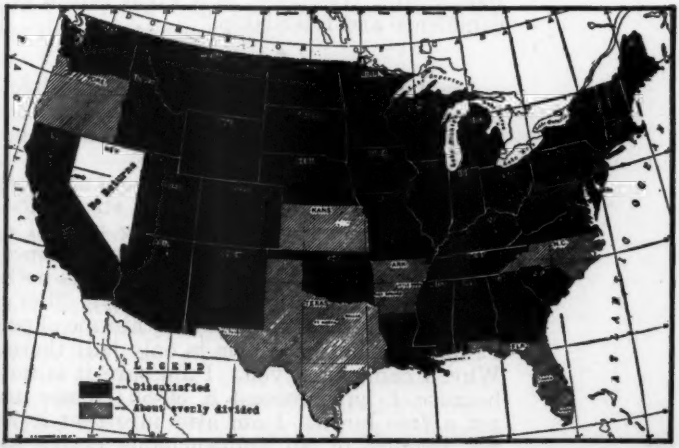
"Those physicians who favor the repeal of the Volstead Act are firmly convinced," the article said, "that the public and the majority of politicians will never sanction strict enforcement and that the law itself is doomed to everlasting disrespect."

And so it was.

Today, the country as a whole is in accord with those doctors who spoke out in the pages of MEDICAL ECONOMICS in 1926. Prohibition stands repudiated.

For once, anyway, we of the profession can hand ourselves a bouquet.

We were right!



This map which appeared in June, 1926, MEDICAL ECONOMICS emphasizes the overwhelming dissatisfaction with which doctors at that time regarded prohibition. Physicians in States shown in black were preponderantly out of favor with the experiment. Hundreds of them predicted its ultimate failure.

Shall We Abandon

IT is all wrong, declares a specialist friend of mine, for physicians to treat one another free of charge. His contention is that doctors should bill for services rendered to colleagues, or to the families of colleagues, exactly as they do with any other patients.

For, he argues, the custom of reciprocal treatment is outworn. It was all right in the days when medicine was less complicated, when neighboring physicians could effect a fairly equal exchange of services over a period of years. Today, he tells you, it is different; specialism, X-rays, laboratory procedures, and the general complexity of things, make an equal exchange inconvenient, if not impossible.

My specialist-friend clinches his argument with the statement, "Giving free service to another physician is much like lending money to a friend—it is a great strain on confidence and friendship."

•

I will grant that the argument is plausible, but there are some aspects to the question which do not admit of argument, and one of them is etiquette.

Perhaps I am just old-fashioned, but when I meet an acquaintance on the street just at lunch-time and we sidle along toward a quiet luncheon nook, and my acquaintance suddenly pauses at the doorway, plants both feet firmly on the ground, and says, "Let's make this Dutch," some cog within me slips. From then on, the charm is only half there. Why, I cannot tell you. I am sure it is not because I have missed a 50-50 chance to get a free lunch. I am also sure that it is not because of an unquenchable desire to pay both chceks.

But something has happened to lessen the camaraderie of the occasion, something akin to what would happen should we all

Reciprocal Service?

suddenly take a hard-headed stand against the genteel custom of reciprocal treatment. In the medical profession we have few enough opportunities to display the spirit of fellowship; why give up this one?

Naturally, there will be inequalities in the exchange of services. There are many occasions when it would be obviously unfair to ask a colleague to sacrifice his bread-and-butter time. Again, there are circumstances when it would only be the part of a gentleman to insist upon making a reimbursement in some tactful manner. The power of solving all such difficulties lies in mutual understanding.

After all, there are many things we do in the name of etiquette, such as pausing to let the other chap pass through the door first. One does not argue too seriously about such courtesies, for they are the color in our all too drab pattern of existence.

•

I remember driving into a town in North Carolina, very late one night. At the station where I stopped for gas, there was a strange excitement, which extended up and down the main street. The town's oldest and most beloved physician had been shot by a highwayman. A little crowd had gathered outside the building where he lay on the operating table. Nearby I counted five cars bearing doctors' insignia. These colleagues, some of them from towns fifty miles away, had been glad to come!

Now—assuming that the physician recovered, should those five doctors have rendered bills for their services and mileage, or not?

What do *you* think?

H Sheridan Baketel

THIS DOCTOR'S LEAGUE

Politics On the Spot

By Julius Ferber, M.D.

SURELY you have received at one time or another from your professional organization eleventh-hour warnings of certain pending legislation inimical alike to the best interests of the medical profession and the public health.

Do something about it, you are urged—write, telegraph, or call upon your representatives in the legislature. But do you? And if you do, is it not usually your impression that your efforts are futile?

•

All these scattered individual protests are about as effective as a discharge of bird-shot would be against the tough hide of an elephant. For opinions, regardless of their unselfishness or true worth, count for little in our democracy—unless they are backed up by a sizeable voting power.

Physicians and members of the professions most closely allied to medicine, namely dentistry and pharmacy, have important interests which are always being threatened in the various legislatures. Ill-informed and lobbyist-influenced individual legislators are constantly introducing for the consideration of their colleagues (usually equally uninformed on the subject of public health) legislation looking toward the breaking down of the meager legal safeguards against cultists and irregular practitioners.

Only in recent years have the allied professions been fully awake to the need of watching all medical legislation with the greatest care. Public health measures and legislation regulating the art of healing have been a favorite hobby of lobbyists altogether indifferent to or opposed to the opinion of the organized professions which ought to exercise the greatest influence in public health matters.

Organized medicine as such cannot enter political activities. True, committees on medical legislation have been named to read bills introduced, pass upon them, and, if they are found to be unfavorable to the profession, write to legislators or appear at legislative hearings on the objectionable bills. However, it is but natural that this means of influencing medical legislation should also fail.

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What is needed is an independent organization devoted exclusively to legislative matters of interest to the allied professions —an organization in which each regularly licensed professional can participate.

Such an organization is the Physicians and Allied Professions Political League, Inc. of New York City, a membership corporation whose purpose is to provide organized and coordinated professional opinion in regard to matters concerning the public health and medical care, as well as the interests of the professions.

The League is non-partisan, with no interest whatever in political office or patronage, nor in the political fortunes of any person or group. It exists to acquaint the various political organizations with the need of safeguarding not

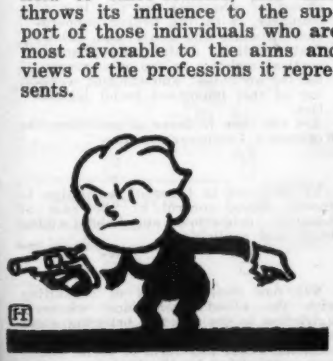
KEEPS MEDICAL LEGISLATION UNDER ITS THUMB

only public health but its legitimate practitioners. Specifically, its main purpose is to line up enough voting power to make itself an effective point of contact between the organized professions and political organizations.

For the League recognizes the power of the vote. It knows that frequently it is the only language the office seeker understands. A Commissioner of Records may not be able to read and write the English language—nor any other, so far as that is concerned—but you may be sure he knows the value of the cross in the "yes" or "no" box of a ballot.

•

The League knows, too, that a vote represents influence and persuasive power only *before* it is cast. With this point always kept in mind, the League makes no particular effort to influence legislators and political groups once in office. Rather it seeks to impress its message upon the whole field of office-seekers, and then throws its influence to the support of those individuals who are most favorable to the aims and views of the professions it represents.



Its methods are direct and effective. Before election it sounds out the various candidates on specific issues. This it does through the usual questionnaire, its attitude toward the particular office-seeker being determined by the unmistakable trend of mind the answers reveal.

•

Before the November elections, the League submitted a simple, direct, one-query questionnaire to the candidates running for office in the Greater City of New York:

1. Do you favor the payment of the medical fees which the City collects for compensation cases treated in City Hospitals to the physicians and dentists who treat these cases?

The only excuse offered by the officials of the City for retaining the medical and dental fees collected for compensation cases treated in City Hospitals is the fact that the City needs the money. This may be so, but this is certainly no excuse for class taxation. There is no earthly excuse why a small group of citizens should bear the burden of additional taxes as the reward for the many arduous services they are rendering the poor in the City Hospitals. The City pays for each and every service rendered in its Hospitals except those of the physicians and dentists. It is ironical indeed to have these professionals taxed in addition to the regular taxes they pay as citizens in this community.

Are you in favor of amending that part of the Charter so as to correct this evil?

Yes ☐ No ☐

And is there any measurable effect so far? The League points out that today fourteen out of the eighteen votes of the New York City Board of Estimate, for example, represent officials who, as candidates before election, answered this questionnaire to the League's satisfaction.

The League's interest in the

State elections is possibly even more keen. To all candidates running for office in the State of New York it submitted a much more elaborate questionnaire than that prepared for candidates on the metropolitan tickets. It was as follows:

I. What is your stand with regard to the (1) anti-vaccination and (2) anti-vivisection bills?

(a) Since the practice of vaccination against smallpox was inaugurated, millions of human lives have been saved, and smallpox epidemics are practically unknown in the civilized communities where every individual is vaccinated. Cases of smallpox reported now and then in our country, have repeatedly been shown to occur in individuals who have never been vaccinated or if vaccinated have outrun the immunity conferred by a single vaccination, and are therefore in need of another vaccination.

(b) Vivisection or animal experimentation is responsible for the marvelous advances in medical science in the last fifty years. Insulin, diphtheria and tetanus anti-toxins, the treatment of rabies or dog bite, etc., would have been impossible without medical research and experiments on animals.

Are you mindful of these blessings to mankind and are you ready to vote against the perennially-introduced anti-vaccination and anti-vivisection bills?

Yes ☐ No ☐

II. Do you favor the amendment of the Dispensary Laws with regard to communities with a population of a million and over to the end of obviating dispensary abuse with reference to physicians, dentists, and druggists and bring about an enforcement of the Dispensary Laws?

The Dispensary Law states definitely that only the indigent sick are to be treated in dispensaries, but does not provide for any instrumentality to determine whether the applicant is indigent or not. At present in the City of New York no effort is being made by many dispensaries to sift out the undeserving, with the result that those who can afford to pay the various charges by dispensaries (some of which go as high as fifteen dollars and more for certain examinations) crowd out the deserving poor. Moreover, the members of the allied professions who contribute their services gratis to the dispensaries are made to compete with themselves and are thus deprived of a livelihood—a very peculiar compensation for their humanitarian work.

Are you in favor of amending the Dispensary Laws so as to fix the responsibility on the dispensaries to determine the status of their applicants? Every philanthropic institution, either governmental or lay, makes a thorough investigation of its applicants. The dispensaries are at present an exception to this rule.

Yes ☐ No ☐

III. Do you favor the strict enforcement of the Medical Practice Act and are you prepared to oppose the extension of any further privileges to osteopaths, physio-therapists, etc., etc., under the Medical Practice Act?

Yes ☐ No ☐

IV. Are you against the legalization of chiropractors, naturopaths, and all other cults?

The Medical Practice Act has been enacted primarily for the purpose of protecting the public against commercialism and cults in the practice of medicine. The administration of this act lacks enthusiasm and perseverance on the part of the officials entrusted with its enforcement. Moreover, there is constant pressure from old and new bodies who are not permitted by law to practice medicine, to break down the meager protection of this law and to admit into the practice of medicine chiropractors, naturopaths, etc.

Yes ☐ No ☐

V. Are you in favor of amending the Workmen's Compensation Act in order to allow free choice of physicians to the injured emplo,ee?

Repeated official and unofficial investigations have shown that the present Workmen's Compensation Law, which does not provide for free choice of physician by the injured employee, has brought about the basest form of commercialism to the detriment of the injured employee while offering no protection to the employer or insurance carrier. Free choice of physician by the injured employee, with the proper cooperation between the State and official State medical, dental, and pharmaceutical societies, is the only guarantee for an honest and efficient working of this important social legislation.

Are you then in favor of amending the Workmen's Compensation Law?

Yes ☐ No ☐

VI. Are you in favor of legislation to provide State control of the sale of poisonous, deleterious, and habit-forming drugs and medicines?

Yes ☐ No ☐

VII. Are you in favor of consulting with the allied professions whenever legislation to the effect of bringing about state medicine or the socialization of medicine under any form of social health insurance, either by the State, organized

"For those who are UNDERWEIGHT"

At this season of the year when bodily resistance is at its lowest ebb and so many patients—particularly little children—are underweight, it is well to remember that Maltine With Cod Liver Oil has been prescribed by physicians for more than 50 years to correct those very conditions. One physician* writes us, "For those who are underweight I prescribe Maltine With Cod Liver Oil."

While the value of cod liver oil as an aid in building up resistance and weight is thoroughly recognized, it is a matter of concern to physicians that plain cod liver oil is not well tolerated by some infants and children. Maltine With Cod Liver Oil, on the other hand, is well tolerated and easily assimilated by all ages.

Containing, as it does, 70% Maltine—a concentrated liquid extract of the nourishing elements of malted barley, wheat and oats—good sources of vitamins B and G, and 30% pure, vitamin-tested cod liver oil of high potency in vitamins A and D, Maltine With Cod Liver Oil is not only rich in the four vitamins, but in other elements essential to health and growth.

Maltine With Cod Liver Oil is biologically standardized and guaranteed to contain four vitamins—A, B, D and G. When administered in either orange or tomato juice, vitamin C is added. Biological report sent to physicians on request. The Maltine Company, *Est.* 1875, 30 Vesey Street, New York, N. Y.

* *Name on request.*

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Reg. U. S. Pat. Off.

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Member NRA
We do our part

ACCEPTED AMERICAN MEDICAL ASSN.

Certifoods—sieved vegetables of known and guaranteed vitamin potency. Prepared by an exclusive process which conserves maximum vitamin values, proteins, calories and mineral salts—particularly iron and phosphorus. Prepared by Certifoods, Inc., subsidiary of The Maltine Company.

philanthropy, or insurance companies, is brought before the legislation?

Yes ☐ No ☐

VIII. Are you in favor of enforcing the law against corporations practicing medicine?

Yes ☐ No ☐

Signed_____

The Physicians and Allied Professions Political League is undertaking to do in the East somewhat the same thing the Public Health League of California is doing in the West.

As set forth in its Constitution and By-laws, the California organization has the following purposes:

To protect the public health by the preservation of modern scientific medicine, dentistry, and nursing, and to strive by legitimate publicity and effort—

(a) To encourage high standards in public health activity.

(b) To maintain the proper relationship between the patient and the physician, dentist, and nurse; and to oppose all objectionable forms of socialized medicine.

(c) To encourage the enactment of laws promoting greater usefulness of medicine, dentistry, and nursing, and to protect the unsuspecting from quackery, patent nostrums, and fraudulent advertising.

(d) To make systematic and intensive studies of social, economic, and legal subjects pertaining to the preservation of health and the care of the sick and injured.

(e) To protect the private physician, dentist, nurse, and hospital from unfair competition by those that are tax-supported or charity-supported.

Philanthropy has had its day. It promised improved health conditions for the community, eradication of disease and proper medical care to everyone for the asking. And what, actually, do we find at the present?

Our city hospitals and dispensaries are crowded, taxing the capacity of overworked and unpaid physicians to give proper medical care. In private hospitals having few or no free beds, private rooms are empty, and the hospitals are in desperate need of funds. And so dispensaries in the private hospitals charge fees exceeding, frequently, those charged in the doctor's offices. Thus the sick who probably can afford to pay are allowed to crowd out the genuinely indigent patients, and the physicians are forced to compete with themselves.

•

Alone, the individual physician can do nothing, or almost nothing, to combat the evils which are already here or looming up on the horizon. He must organize to meet them, or suffer failure.

Like the California Public Health League, which "seeks to weld into a formidable political unit those elements of society—both professional and lay—that believe in the highest professional standards and a square deal for the taxpayer: those elements that stand against paternalism, quackery, nostrum vending, false advertising, misrepresentation and fraud," The Physicians and Allied Professions Political League is decidedly interested in legislators and public officials generally.

However, as I have already suggested, unlike our Western brethren who pin their faith on lobbying in order to block pernicious bills and to secure the passage of favorable legislation, we try to remove the *cause* of many legislative ills:

We put the emphasis back on the candidate, knowing that if we can help influence the election of the right-minded candidate we will have taken the biggest possible step "to protect the public health by the preservation of modern scientific medicine."

It's a G. P.'s Office— and

I SET ASIDE TWO ROOMS

By H. G. Bull, M.D.

IN a general practice in which there is a rather thick sprinkling of children, there are obvious advantages in making the doctor's office so attractive to these little folks that they will look forward to coming there.

As a matter of fact it can be made so attractive that they will only leave with reluctance. That is excellent psychology, not only for the small patients themselves, but for their parents and for the doctor too.

•

For a long time I had regarded the situation in my own office with an apologetic conscience. It hardly seemed a square deal for the young patients to have nothing more entertaining, reassuring or inspiring to do while awaiting their turn than to sit on an elder's lap or lean against their mother's knee, or at best look out of the window.

There were magazines—good ones, medium ones, and poor ones —with which the adults could while away tedious minutes or quarter-hours, and among the advertising pages were to be found cars and dogs and airplanes, in case an elder was kind enough to seek them out and interest the child in them; but that was at best a small attraction to offer.

There are several reasons why these most entertaining of all patients should be entertained in the waiting room. In the first place most of those who come to the office are not very ill; if they were they wouldn't be there. They come for vaccination, immunization against diphtheria, scarlet fever or typhoid, for general physicals, or for some of the many problems of hygiene or feeding that precede the teens.

Sick children in the office are not common, and it is usually very easy to spot them and run them into another room until they can be taken care of. It is the pleasant, restless runabouts that I am writing for, and my own experience proves to me that it is well worth going to some little trouble to make their interval of waiting a pleasant prelude to their encounter with the gentleman who is to prick them or scratch them or make them say *ah*.

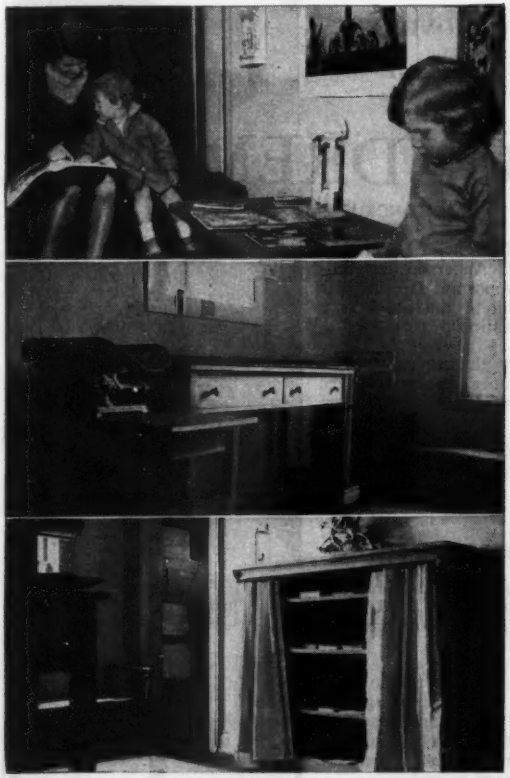
•

In adding another room to my office, using one for children's work alone, I found that I could dispense with the services of a small hall that had been used as a passageway in going from one room to another. It opens from the general waiting room, and is only about five feet wide and eight long.

That, I decided, should be my children's waiting room. The end was walled up with beaver board and a bench put across it, low enough to be acceptable to children and yet not too low for a mother who might feel like sitting with her offspring. On the bench was a cushion, and behind it a long, gay piece of tapestry.

Some small furniture—a table, a bench, an armchair and a bookcase—and a rug—completed the furnishings, for what could be

Children Like It



(Top photograph) The hall that became a special children's waiting room. The dimensions are only five feet by eight, yet three groups can be seated at one time.

(Middle photograph) A corner of the children's examining room. The bulletin board above the table shows tables of growth and development.

(Bottom photograph) The opposite corner of the children's examining room.

done in a room five by eight? On the wall were put a mirror, a Della Robbia of the singing boys, some animal pictures and a gay block print.

The little bookcase holds magazines—Junior Home, Child Life, John Martin's Book—and on the top shelf is a collection of small toys—animals, men, houses, and whatever comes along that is tiny. On the little table are small books for small people, including a good supply of the Mother Goose Rhymes that the Metropolitan Co. puts out for free distribution. The children always want to carry something home, and to avoid disappointment and not encourage thievery these nice little books serve a grand purpose!

Here they sit, these very young people, busy and well entertained. Even in these small quarters there is room for three separate groups. When their turn comes to see the doctor they approach the encounter in a frame of mind that is very conducive to friendly trust and to confidence.

In the room that is now devoted exclusively to children's work an effort has also been made to make the place seem pleasant. The walls are very light green with red monk's-cloth used for a curtain and for a cushion for the daybed. On the floor is a pretty linoleum in shades of light green.

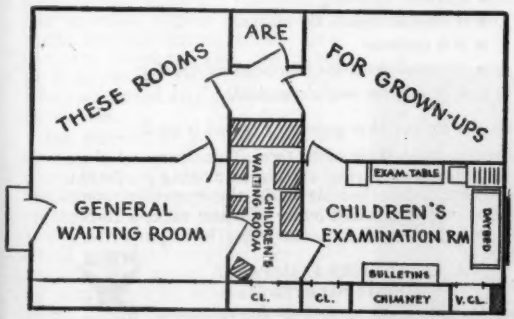
On one side of the room is an examining table made especially for the purpose, of a convenient height, equipped with a soft cushion, and with two drawers. In one of these are paper bath-towels, one of which is spread out on the table for each child, to be undressed and examined on.

A supply of paper diapers is also kept on hand to be used by the mother who came unprepared or for the child who had to wait too long. Baby scales are at one end of the examining table and scales for larger children and adults at the other.

Across the room is a bookcase, hung with washable curtains of Irish linen, with a green stripe, in which are kept bulletins for free distribution. These are published by the Children's Bureau at Washington, by the State Department of Health, and by certain companies and corporations whose work in the field of public health is most helpful to mothers. The manner in which the subjects are treated is so concise, so accurate and withal so pleasing, that it is small wonder that the mothers are eager to get them and read them. Among these pamphlets are several meant especially for children, and these are distributed with a free hand.

On the wall of this room is a bulletin-board to which are thumb-tacked the different tables for heights and weights, development

[*Continued on page* 55]



This plan shows the relation of the children's rooms to the office in general. Circulation of child-patients and adults does not conflict.

It's the Location That Counts . . . . . .

THERE was in my class at medical school a fellow much older than the average. He had been a special student at the extension department for many years, making up the entrance requirements for the preliminary degree.

I learned indirectly that this fellow (let's call him Smith) had been and still was a plumber—a regular, everyday plumber. Never any too bright, he worked hard, always managing to pass the courses. At graduation he accepted a short interneship at a small out-of-the-way community hospital.

From there he sought another small community adjacent to New York City. It was an insignificant place and just near enough to several medical communities to make it unattractive to most physicians.

•

Dr. Smith took a house at the far end of town and put a small sign in the window. He went to the business section of town and made himself known to the grocer, the butcher, and the baker as a physician from the big city who had found city conditions unfavorable.

He wished to go into semi-retirement, he said, but he made it plain that, as a good neighbor, he would be willing to be called in emergency by his friends. Or, if they wished him to take care of small matters for which they did not feel they ought to go to town, he would not be offended if they went to their regular doctor in town for the more important matters.

I have understood that Dr. Smith intimated he had been licensed for twenty years, not specifying that it was as a plumber that he held this license.

Dr. Smith was very successful in this small community. He took time to show an interest in civic affairs. His knowledge of business and business methods fitted him for the official position he secured in forming the local bank. And his contacts through this position brought him to the notice of the officers of the railroad so that he became division surgeon.

As the city grew out to this suburb, he found himself well-established, with a good income. He was still an "old" doctor.

This story may have little point in itself except for the following. Some years ago, an old friend of mine found himself out of a medical job. He had never practiced, except for a corporation, and at that particular moment the corporation needed a goat, and he was it.

Through no fault of his own, he found himself without resources. His wages while good

had been exhausted in sending two children to college and in living. The job from which he had been ousted had seemed secure.

Without savings, this doctor—we will call him Jones—had to ask a sister to lodge him and his wife. He felt that there was no future for him, and that the conditions under which he had left his former employers made a similar job impossible.

One day he came to me and told me his story. In return, I told him the story of Dr. Smith, and advised him to seek a small community and try the same tactics. My advice was to find a small place within commuting distance of New York City, a town of about two thousand persons, and set up as an emergency physician, with the expectation that he could in time develop a practice.

Dr. Jones was very grateful to me, and told me that he would try to find the type of community I described, as he felt that he was not equipped to enter regular general practice. He also told me that he would remember me, and would send me any patients who needed the special services I was equipped to render.

Some weeks later, Dr. Jones called me by phone and told me that he was coming up with a patient. When we had finished with the patient, he sat down and told me how he followed my advice.

He reviewed the type of community I wanted him to find and the type of practice he felt he could do. The conditions were very particular. He could not undertake obstetric work, for he had not delivered for twenty or more years. Operative work was beyond his recent experience. He had reached the age when he had to consider his own health, and his long years of office-desk medicine had given him the nine-to-five spirit. His special training was in physical examination, but what small community could support his type of specialty?

Dr. Jones reached the conclusion that such a community existed right in the heart of New York City. He took the subway to Battery Park. He began to walk up the east side of Broadway.

He was a stunning figure of a man, very tall, with a long, thin face and neatly trimmed moustache. He was invariably well-dressed and carried a stick.

He walked into each tall office building and inquired at the information desk if there were a doctor in the building whom he could consult in an emergency. In those buildings where the answer was "yes," he thanked the clerk and walked out.

After a short walk through the great canyon, he came to a tall building where he was told that there was no physician available.

The building could use the services of one, too. There were calls many times each day, at which times the management was forced either to send for an ambulance, or to refer the patient for attention to one or another of the insurance company offices lower down on Broadway.

Dr. Jones needed no other information. He went at once to the renting agent, told him exactly what his position was, and rented a small one-room office at a nominal figure. The agent directed all elevator men and other employees to refer medical cases,

NO FISHY TASTE because they contain the PALATABLE FRUIT AND VEGETABLE FORM OF VITAMIN A

CARITOL, *for A, alone*—

Caritol is a 0.3% solution of Carotene ($C_{40}H_{56}$), the palatable fruit and vegetable form of vitamin A, and therefore represents the form in which most vitamin A is naturally consumed by the human body.

Helps Build Resistance and Promotes Growth

Caritol, by virtue of its vitamin A activity, promotes growth and, as indicated by experimental studies, may be an aid toward the establishment of resistance of the body to infections in general. It may be prescribed alone or with other vitamin products. There is no fishy taste or bad after-taste. The cost is reasonable, too. Caritol is available in 15 c.c. and 50 c.c. dropper-top bottles and in capsules packed 25 and 50 to the box.

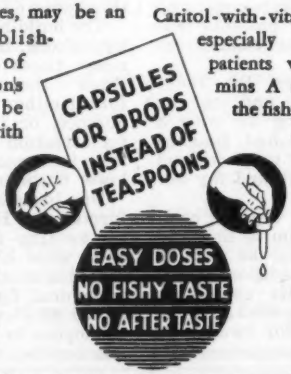
CARITOL-with-Vitamin D

Caritol-with-vitamin D is the most palatable combination of vitamins A and D on the market because it contains the fruit and vegetable form of vitamin A, carotene, and a tasteless vitamin D prepared for therapeutic use by methods (Zucker process) developed at Columbia University. It is naturally palatable, not artificially flavored.

For A and D, together in Palatable Form

Caritol-with-vitamin D is, therefore, especially recommended for patients who need both vitamins A and D, but object to the fishy taste of fish liver oils and their concentrates.

There is no fishy taste or bad after-taste, and the cost is reasonable. Available at prescription pharmacies in 5 c.c. and 50 c.c. dropper-top bottles and in 25-capsule boxes.



Prescribe these naturally palatable vitamin products — they cost no more.

S.M.A. CORPORATION OF U.S. CLEVELAND, OHIO

"World's Largest Producer of Carotene"

emergency work, and other medical matters to Dr. Jones.

Further than that, learning of his special practice in physical examination, the agent introduced Dr. Jones to a tenant who required a health certificate from all prospective employees before hiring them, and also before they were sent to serve in branch offices throughout the world.

Here was a ready-made practice in a small community of no less than 5,000 residents, all adults, and a floating population no less than 20,000. The time they were about was from eight to six. There was no opportunity of having to treat seriously ill people, since they did not attempt to go to the office at all if they were that ill.

The practice did not interfere with that of any other physician the patient might have. Since a good many people lack family physicians, Dr. Jones was enabled to build up a fairly large circle of specialists to whom he went with his patients to learn the procedures, so that in a short time he purchased a fluoroscope, a high-frequency machine, and an ultra-violet apparatus. Before long, too, he extended his office space.

His practice in physical examination work grew apace as other firms in the downtown district learned of his work. The prospective employees or the fellow about to be transferred to tropical ports found a physician in his immediate neighborhood.

And so, despite the depression, under these particular conditions Dr. Jones continued to prosper in a special community within the confines of our largest city.

No, a doctor cannot send for patients,—*but he can so place himself that the patients will come to him.*

•

Oust the sample racketeer!

SOME physicians have heard of "sample racketeering." Others have not.

At all events, it is something in which to avoid becoming involved. In the past year or two a regular "business" of this sort has taken root.

A man will come into a physician's office and ask if he has any samples he can buy. If the doctor says no, the man generally inquires if he may call again later for the same purpose. The object in all this, of course, is to sell the samples to other people.

Whereas no physician would lend himself knowingly to the practice, it is sometimes promoted by an irresponsible assistant or other person in his office.

At first glance, sample racketeering seems to be just another dishonest practice. But there is more to it than just that. Anyone who tends to further its development either unwittingly or otherwise, is doing four things:

1. Sponsoring a serious and fast-growing racket;
2. Interfering with the legitimate business of pharmaceutical manufacturers;
3. Raising the cost of pharmaceuticals to the doctor;
4. Promoting self-medication.

All that is needed to combat this relatively new brand of racketeering is for each doctor to make a simple check-up within his own office. If this can eliminate a reprehensible practice, it certainly is worth it.

Gingivitis and Controlled by Diet in

Dental disorders of 440 Mooseheart children respond to daily ingestion of fresh orange and lemon juice

Results in Brief:

GINGIVITIS

1st year (standard diet), incidence	74.9%
2nd year (standard diet + citrus fruit juices)	12.4%
3rd year (standard diet, recheck period)	60.3%

DENTAL CARIES

1st year (standard diet), incidence	78.0%
2nd year (standard diet + citrus fruit juices)	33.7%
3rd year (standard diet, recheck period)	83.4%

HEIGHT GAIN (BOYS)

1st year (standard diet), av. gain, 13-yr. group	1.6 in.
2nd year (standard diet + citrus fruit juices)	2.8 in.
3rd year (standard diet, recheck period)	2.5 in.

WEIGHT GAIN (BOYS)

1st year (standard diet), av. gain, 13-yr. group	8 lb.
2nd year (standard diet + citrus fruit juices)	15 lb.
3rd year (standard diet, recheck period)	12½ lb.

"THE addition of a pint of orange juice and the juice of one lemon to a diet that is nearly adequate in all other respects supplies something that leads to a disappearance of most of the gingivitis and an arrest of about 50% of the dental caries."

This is one of the conclusions announced in "Diet and Dental Health," a monograph published by the University of Chicago Press. It reports the results of a three and one-half year study made at Mooseheart by The Sprague Memorial Institute at the University of Chicago.

American Diet Deficient

"The average American diet," the conclusions also state, "is adequate in calories but appears to be deficient in certain substances that are requisite to dental health. This dietary deficiency may be the ultimate cause of much of the gingivitis, pyorrhea and dental caries with which we are afflicted.

"Gingivitis and dental caries can occur in the majority of a large group of children who are receiving a quart of milk, one and one-half ounces of butter, a pound of vegetables, half a pound of fruit and nearly one egg a day. These foods do not, therefore, contain substances that are specifically antagonistic to gingivitis or dental caries.

Ample Citrus Fruit Juice Required

"Dental caries again becomes rampant and gingivitis redevelops in most of the cases when the citrus fruit intake is reduced to three ounces a day for one year. Three ounces is not enough.

"Children display a definite tendency

Dental Caries 3½-year Clinical Study

Physicians: Monograph gives full details of the most comprehensive nutritional study of children ever made

toward the development of carious lesions which is nil or low in some cases and high in others. This tendency can, perhaps, be ascribed to heredity. The administration of an adequate amount of citrus fruit juice to a diet that is nearly adequate in other respects reduces the intensity of the carious process; but does not completely remove the effects of the inherent tendency in all cases.

Rate of Growth Improved

"Orange and lemon juice contain something that acts as a growth stimulus to children."

How Study Was Begun

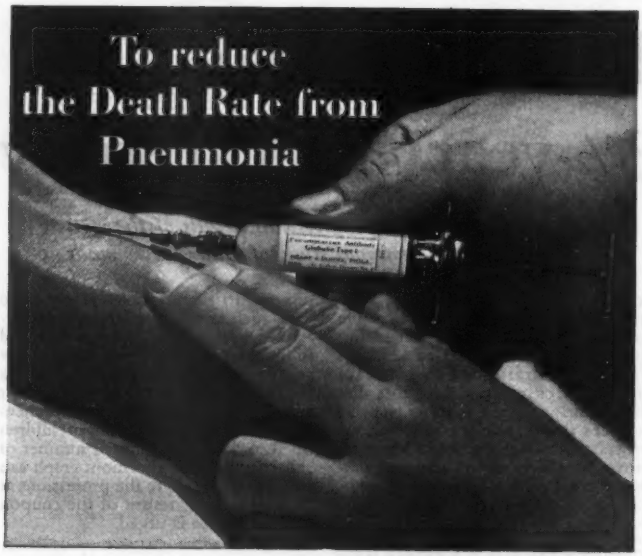
This study was the outgrowth of preliminary work by Dr. Milton T. Hanke, Associate Professor of Biochemistry in the Department of Pathology, and a member of The Sprague Memorial Institute at the University of Chicago, in collaboration with the Chicago Dental Research Club.

At the instance of this group and the Institute, the California Fruit Growers Exchange agreed to furnish fruit and additional funds to guarantee the completion of the research.

And for the monograph, the California Fruit Growers Exchange made available to the University of Chicago Press forty-eight costly color engravings and other plates. This makes it possible for the Special Advance ($1) Edition to contain the identical full-color illustrations to be used in the regular $4 edition.

Physicians: Send For Book

Physicians and Nutritionists, as well as Dentists, will find much of the clinical material in "Diet and Dental Health" directed to them. Tables give precise data, such as serum calcium, oral bacteriology, etc., on all children included in the three and a half year Mooseheart study group. This permits correlations for various purposes. The Mooseheart research is easily the most comprehensive clinical nutritional study of children on record. Only a limited number of subscriptions for the monograph can be made available to the professions at $1, and an early return of the coupon and remittance is urged.



A STEP FORWARD in reducing the death rate from pneumonia has been found in concentrated and standardized Pneumococcus Antibody Globulin Type I Mulford, prepared according to the method of Felton.

The use of this serum has shown beneficial effect. Definite improvement usually appears within thirty hours after antibody administration and the average duration of illness is shorter than that of untreated patients. Best results are obtained when administered early in the disease.

Therefore, its *concentration* has important therapeutic significance as tests show a protective value ten or more times that of the serum from which it was made. Its *standardization* means certainty in dosage and uniformity of therapeutic expectation.

Serum sickness is minimized as the refining processes remove most of the serum proteins; the allergic type of reaction is fortunately rare.

Further information will be supplied on request.

MULFORD BIOLOGICAL LABORATORIES

Sharp & Dohme

Philadelphia Baltimore Montreal

Pneumococcus Antibody Globulin Type I Mulford

Miscellanea

[*Continued from page* 22]

"We have been operating for 2,500 years under our own code—the Hippocratic oath," said Dr. Skinner. "To us NRA means Never Refuse Aid. The public needs no outside regulation of doctors who are faithful to their profession."

•

At its recent semi-annual meeting in Washington, the American Pharmaceutical Manufacturers Association resolved that it (1) "approves a sound constructive, and early revision of the Federal Food and Drugs Act, to correct its defects and adequately to realize its high intendment of public protection; (2) approves the purpose of the so-called 'Tugwell Bill,' to accomplish such a revision of the Act; (3) regretfully disapproves the 'Tugwell Bill' because it is not drawn in due form; (4) pledges its immediate action to suggest an effective substitute bill drawn in due form and directed to provide a basis for general concurrence in the circumstances."

•

Denver (Colo.) physicians are seeking to curb free medical care by requesting police surgeons to question all accident victims about their ability to pay. During November the Denver County Medical Society adopted a report containing four recommendations, two of which follow:

That police surgeons should make an increased effort to place emergency cases in private hospitals.

That each emergency case not entitled to charity should be attended at the hospital by a physician of the patient's own choosing, such patients to be segregated in the hospital and considered liable for their hospitalization charges.

Dr. George L. Monson, a member of the committee that offered these recommendations, urged that every police surgeon be supplied with a card bearing questions to be asked each emergency case as to the doctor and hospital the patient preferred, and that if a private hospital was named, the patient should be taken there.

•

In a new monograph, Diet and Dental Health, by Milton T. Hanke (University of Chicago Press, $1) the author, associate professor of biochemistry at the University of Chicago, presents the findings of a 3½-year nutritional study of 440 children at the Mooseheart Home, in Illinois.

The study, sponsored jointly by the Sprague Memorial Institute of the University, the Chicago Dental Research Club, and the California Fruit Growers Exchange, emphasizes the effects of diet in controlling dental caries and gingivitis, and is said to be the most comprehensive nutritional survey of children ever made.

Tables give precise data on serum, calcium, oral bacteriology, and so forth, presented in such a way as to allow correlations for other purposes. Forty-eight costly color engravings are also included.

•

What is the Federal Trade Commission going to do about the misleading branding of shoes known as "Doctor So-and-So's Shoe," or "Designed by Doctor So-and-So?"

A New York City orthopedist, Dr. Norman D. Mattison, has raised the issue. He submits a list of 175 trade names in which the designation "Doctor" is employed. How many of these shoes, he asks, are created by physicians as to last or otherwise? And are those which are

MAXIMUM TENACITY
at body temperature
MAXIMUM CONVENIENCE
all the time!

BAYHESIVE attains maximum tenacity at body temperature—a fact which has established its popularity. And it is available in special forms of particular convenience. Standard widths come in the dustproof, free-reeling BAY container that is handy to use and protects the plaster. Convenient eighth and quarter inch strips can be had on reels two inches wide.

Readi-cut rolls for use in the new improved BAY wall rack facilitate handling in clinics—the closed rack is not marked by visible advertising insignia.

BAY'S one-inch Readi-Bandages come in handy, professional packages of 100; the six-inch width is packed six to a box.

Physicians who specify "BAY'S" receive maximum efficiency and convenience—at no increase in cost.

THE BAY COMPANY
BRIDGEPORT CONNECTICUT
A DIVISION OF
PARKE, DAVIS & CO.

THE BAY COMPANY ME-12
Bridgeport, Conn.
Gentlemen: Please send me a sample of BAYHESIVE.

Doctor .....
Address .....
City..... State.....

not so created misbranded, according to the Code of Fair Competition of the shoe industry?

The value of a shoe bearing the designation of "Doctor" would appear to be enhanced by the implied assurance that a physician designed the last over which this particular shoe was made, or that it was otherwise improved upon by him over the usual design and construction.

The result, Dr. Mattison points out, is to indicate to the public a health or remedial feature existing in these "Doctor" shoes which is not found in other shoes.

Actually, he is convinced, the majority of "doctors" sponsoring "Doctor" shoes are shoe men having no connection whatever with the profession. And shoe men as a group, he declares, have learned little or nothing about the morphology and structural anatomy of the foot.

Conversely, it is safe to assume that even the few *bonafide* physicians lending their names to shoe promotion interests know little of shoe construction.

•

In connection with its current publicity campaign, the Philadelphia County Medical Society has produced a motion picture film dealing with the family physician. It describes the doctor's background, his training in medicine, the cost of his education, the type of professional service he offers, and the extent of the charity work he does for indigent patients.

•

A plan of systematic dental care for New York's 1,600,000 school and pre-school children was advocated last month by Dr. Shirley W. Wynne, city health commissioner.

As advocated, the proposal would involve an expenditure of ten dollars a year for each child during the first two years, the cost thereafter dropping to five dollars per child per year.

Dr. Charles Gordon Heyd, past president of the Medical Society of the State of New York, is lending his support to the program. He states that it costs $105.11 a year to educate a child, and that an additional ten dollars a year would be "money well spent."

•

As its contribution to the eighth annual observance of National Pharmacy Week, the National Wholesale Druggists Association has published a Medical Plant Map of the United States. The map is lithographed in nine colors, and measures five feet four inches by three feet eight inches in size. Not only does it describe a wealth of medicinal plants in the United States, but it also indicates their geographical habitats. A number of foreign medicinal plants is also included, and there are 125 illustrations in all.

Although this map was not prepared for distribution to physicians, arrangements have been made so that as long as the supply lasts, any reader of MEDICAL ECONOMICS can obtain a copy without charge by writing to the National Wholesale Druggists Association, 51 Maiden Lane, New York City.

•

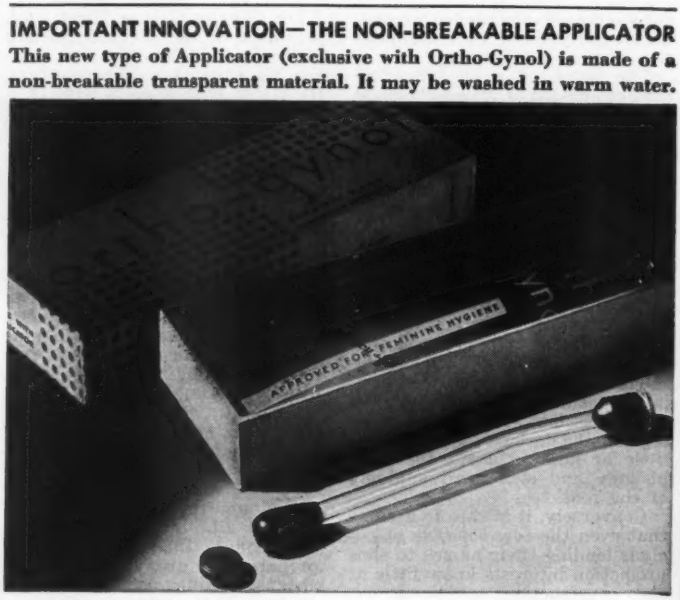
All the excitement and strain of an interne's crowded days and nights are packed into an absorbing little volume, *My First Baby and Other Ambulance Anecdotes*, just written by "The Interne" (Macrae-Smith, Philadelphia, $1).

In it a now well-known surgeon, writing originally for the amusement of his profesional colleagues, recounts episodes in that side of hospital life which falls to the lot of the young ambulance surgeon and dispensary interne.

Humor and zest characterize the story. Following the interne through the fast-moving pages, we live a diversity of roles: furiously clanging the bells as,

IMPORTANT INNOVATION—THE NON-BREAKABLE APPLICATOR

This new type of Applicator (exclusive with Ortho-Gynol) is made of a non-breakable transparent material. It may be washed in warm water.



IMPLICIT CONFIDENCE

PROFESSIONAL background—proved dependability—ethical introduction—its strict standards have earned for Ortho-Gynol the Implicit Confidence of physicians. Laboratory research—clinical tests—followed by widespread professional endorsement and successful use by thousands of women patients—such history has emphasized Ortho-Gynol's first place in the field of Vaginal Hygiene.

The efficacy of this preparation is based upon double protection, mechanical as well as chemical. The base of Ortho-Gynol is a combination of gums of unusual tenacity. It entangles the motile cells and resists solution for several hours. Its antiseptic ingredients are adequate. Ortho-Gynol may be prescribed for Vaginal Hygiene with or without pessary as your judgment dictates. You may likewise prescribe Ortho-Gynol for local treatment of Vaginitis and Leukorrhea.

Complimentary Package

Ortho-Gynol is available through your pharmacist or regular suppliers. But to any practicing physician who has not already been supplied, we shall gladly send a full-sized tube of Ortho-Gynol with the new transparent, non-breakable applicator (actual value $1.50).

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NEW BRUNSWICK N.J.U.S.A.

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APPROVED
FOR VAGINAL HYGIENE

with his ex-firetruck buddy, Sam, at the wheel, he careens madly to the scene of an accident, risking life and property to beat rival hospital outfits to the spot; in the Lower East Side, delivering his first baby—"an obstetrician at last!"; by quick thinking diverting the murderous intentions of a jealous negro husband; avoiding the disgrace of an ambulance birth (and the expense of having to give a dinner to the whole staff) by precipitately transferring a dispensary case from the ambulance to the nearest stylish hotel when the car runs out of gasoline, and there delivering his patient; playing Santa Claus to the ward youngsters; and being himself a delirious influenza case, to emerge from a three-day crisis with the assurance that the sweetest, prettiest nurse in the world is going to continue to take care of him always.

An appropriate Christmas gift, this book, for anyone who has ever been in a hospital as a doctor, nurse, or patient.

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Of the 2,041 mothers who died in childbirth in New York City in 1930, 1931, and 1932, some 65.8 per cent, or 1,343, died because somebody blundered.

That is the opinion of a special committee of the New York Academy of Medicine appointed to investigate the circumstances of 341,879 births in the metropolis.

In the 290-page report recently made public it places the onus largely upon the shoulders of the medical profession. Patients themselves, the committee asserts, were responsible for 36.7 per cent of these preventable deaths, and midwives for 2.2 per cent.

Sixty-one per cent of the avoidable deaths, it emphasizes, are directly attributable to "some incapacity in the attendant: lack of judgment, lack of skill, or inattention to the demands in the case . . . Internes have been given too wide a field of independent activity."

Over-use of anesthesia and instrumentation comes in for censure, too. The committee states that they are necessary in not over five per cent of all delivery cases, yet the records at 67 New York hospitals show operative interference in 24.3 per cent of the cases. It adds that it found the mortality of mothers in homes 1.9 per cent, in contrast to a hospital death rate of 4.5 per cent per 1,000 live births.

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"Physicians should resist efforts to bring about compulsory health insurance legislation," recently declared Dr. John J. O'Reilly, professor of medical jurisprudence at St. John's Law School, Brooklyn, New York.

"Health insurance legislation would interfere with the proper practice of medicine," Dr. O'Reilly held. "It would make the physician infinitely inferior to what he is now. The doctor would be placed under the supervision of political appointees, with resultant standardization and other abuses. The public would suffer in the long run."

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Have you seen Will Roger's picture, *Doctor Bull?* In it Will portrays the general practitioner in a little New England town. He is the whole town's doctor, chronically underpaid and outrageously overworked. "Sleep!" he snorts at one place in the play, "Doctors have to die to get any sleep!"

Aside from mouthing and mumbling some of his lines, Rogers acquits himself well in this picture, as usual, slouching and drawling his way through the role in the likeable, apparently effortless manner which has characterized his other screen stories.

Dr. Bull glorifies the small-town family doctor, bringing out poignantly his sacrifice of personal comfort to the well-being of

DRYCO POLICY AND MEDICAL ETHICS

An Open Letter to the Medical Profession

FOR many years we have been telling the story of Dryco, and later that of Irradiated Dryco, to the medical profession. Physicians have shown a gratifying interest in its scientific background and its practical success.

IRRADIATED Dryco has always been advertised and marketed under a strictly ethical policy. We have not considered it either necessary or becoming to stress this fact in medical journal advertising, since it has always been maintained and could be attested to at any time or place.

WE HAVE solicited your consideration of Dryco as an outstanding food for babies, not because we do not advertise to the laity but because Dryco is a valuable help in feeding infants who have for one reason or another been deprived of breast milk—the oldest and best of all baby foods.

WE ASK your consideration of Dryco because of its years of successful clinical history and its constant scientific progress—not *merely* because we confine our advertising exclusively to the medical profession. We believe physicians place a higher value upon the usefulness and dependability of a product than upon any advertising policy.

THEREFORE, *we base and have always based our medical journal advertising on scientific facts and clinical findings on Irradiated Dryco as a food for infants.*

The DRY MILK COMPANY, INC.
205 EAST 42nd STREET, DEPT. M.E., NEW YORK, N. Y.

others, and emphasizing anew the peculiarly intimate and vital manner in which his personality touches upon the lives of his fellow townsmen, from birth to the grave.

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G. P.'s Office

[*Continued from page* 39]

of the baby in every respect—teeth, strength, accomplishments in sitting up and in walking and talking, as well as the periods of incubation, isolation and quarantine of the communicable diseases. At the bottom of this bulletin board, just where the child can see them in case he needs distraction during his ordeal, are two or three pictures of babies. These always please the patients. In the window above the daybed is a small goldfish bowl, and on the bookcase a spirited Rogers group of a boy astride a galloping mare, with a fat doctor on behind—"Fetching the Doctor."

All in all this small combination of waiting room and examining room for children is proving a great success.

And if you become on good terms with the children the parents in turn are pleased and flattered. Then there is nothing left but the grandparents, and they are a different proposition.

What the Detroit Plan Offers

[*Continued from page* 20]

the program as outlined by the County Medical Society.

The group need not consist of all members of the medical society, nor need it be restricted to those who are members. It must, however, include all who have prepared themselves to participate in the general program and who are willing to subordinate their personal views to that of group judgment.

Instead of being built about a unit or community health service constructed around a clinic or hospital center where a small group of physicians have joined their common interests and purposes, this plan is supervised by a large group of cooperating physicians. The foundation of the program rests upon the shoulders of the family physician, who becomes the unit on which medical practice is constructed.

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At present, 1,100 doctors, comprising from 80% to 90% of Detroit's physicians, exclusive of certain types of specialists, are actively identified with the plan of medical participation, a fact proving conclusively the favor with which the local medical pro-

fession regard the whole project.

The plan does not involve any insurance scheme, but does provide for a reasonable honorarium to physicians who serve in their own offices those who are unable to pay the physician direct. Funds for this purpose are taken from taxes, a regular item for the payment of physicians appearing in the budget of the Detroit Health Department.

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There is need of a better understanding between the organized medical profession and the local public health agency, both of which have a common purpose: the preservation and conservation of human life. Unfortunately, it is not unusual to find in many communities a certain degree of suspicion and antagonism between the county medical society and the health department. The former frowns upon the real or mythical inroad of socialized and state medicine, and yet fails to provide a suitable substitute. Plans and suggestions are proposed, but rarely executed.

The medical society has neither the funds nor the personnel equipped to carry on a community health service. On the other hand, the health officer too frequently has overlooked the viewpoint of the practicing physician. He has allowed his organization to develop so as to interfere with the prerogatives of the physician, and in some instances has enticed into free clinics individuals who can well afford to pay the family physician for his service. In Detroit, during the past six years, the County Medical Society and the Health Department have pooled their resources and have teamed up to solve the problem which is of mutual concern.

One should understand from the outset that not one interested in this plan has at any time contemplated demolishing the public health department or in any manner weakening the organization.

Those who assume that the practice of preventive services in the physician's office warrants the curtailment of funds to the Health Department are bound to be disappointed.

If the Health Department withdraws from the cooperative plan, disaster will result. The two groups, the medical profession and the health agency, must work together, recognizing that they have a common interest in the promotion of positive health, the prevention of disease, and service to the public, particularly the growing child.

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In the city of Detroit there is a health unit virtually within a stone's throw of every residence. Each physician's office has become a health center to which the public is being referred for diphtheria protection, smallpox vaccination, a periodic health examination, and a search for the early case of tuberculosis.

The proximity of the physician's office to the homes of the city has increased materially the percentage of infants and preschool children protected. It is easier to take a child at seven or eight months of age a block or two to a physician's office than it is to travel a greater distance to a central or district clinic. The parents are being trained to turn to the physician's office for health advice rather than to free clinics, or the corner drug store, or the quack.

These cooperating physicians have agreed to abide by certain rules and regulations and to follow out a plan which they themselves have prepared through their County Medical Society in cooperation with the Department of Health. In the diphtheria prevention program a Form of Agreement with the Wayne County Medical Society and the Detroit Department of Health has been signed by each of the 1,100 cooperating physicians. It specifies that on certain days and at

certain hours the cooperating physician will perform a special preventive medical service for a pre-determined price.

The physician agrees at this time to give toxin-antitoxin or toxoid for one dollar per treatment, if in the physician's judgment the parent can pay for the service. There is nothing in this agreement which binds the cooperating physician for any other time than that specified. The specialist or the pediatrician may charge his client any price he chooses at any other hour.

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The physician also agrees that if the parent cannot pay for the service he will protect the child, and the Health Department agrees to reimburse the physician at the rate of fifty cents for each service, or $1.50 for three doses. The Health Department also pays one dollar for the Schick test, which includes the reading of the results.

Under this arrangement, there is every incentive for the physician to charge the parent if he can pay, as the physician receives one dollar instead of fifty cents for each service.

On the other hand, there are many persons who have not learned that preventive medical service is something which can be purchased. They have learned to pay the physician or dentist for a pain in the stomach or an aching tooth, but they have not learned the value of *paying to keep well.*

Consequently, the cooperating physicians have been liberal in their interpretation of the client's ability or willingness to pay for diphtheria immunization. As the program grows older there will be an increasing tendency for the individual to assume the financial responsibility. With free clinics the tendency is in the other direction.

Each cooperating physician is supplied with a record card which he can keep in his own office. In addition to this he is provided with postcards, one of which he mails to the Health Department for each series of toxin-antitoxin or toxoid treatments. On these he records the name, address, and age of the child, indicates the dates on which the treatments have been given, and signs his name and address. The same card is used to report Schick tests.

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We do not generally recommend the Schick test before immunization, but recommend that it be given approximately six months after the first series of treatments. The Schick material, as well as the toxin-antitoxin and toxoid and smallpox vaccine are kept in the culture stations of the Department of Health, and are available to physicians without charge. Report cards are obtained by the physician at the same time

and at the same place that he obtains the immunizing agent.

One thing which too frequently keeps the laymen away from the physician's office is the uncertainty of what the physician is going to do, and how much he is going to charge. This is common to persons who are wealthy as well as to those who are nearly indigent.

This agreement immediately overcomes a very real obstacle. The health agency is able continually to broadcast to the public that there is a group of cooperating physicians who have agreed to perform this service for $1.00 per treatment, or for nothing in case the parent is financially embarrassed. Furthermore, they need have no fear of imposing upon the physician, as the latter is paid an honorarium by the Health Department, a tax-supported agency.

We believe that physicians should be paid for services to indigents. We believe also that it is fair to charge a part of the cost of diphtheria protection against a program of health education.

Remember that diphtheria protection is merely the *immediate* objective. The *ultimate* purpose is to carry the practice of preventive medicine into the office of every qualified physician.

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It has not been an uncommon practice in recent years for health agencies to introduce new projects into a community, the success of which depends upon services which must be rendered by physicians and dentists, without first presenting the entire program in all its aspects to the profession itself.

The apparent lethargy or lack of cooperation on the part of physicians may be due to no small extent to the fact that no effort has been made to stimulate their interest or to gain their confidence. An occasional address before the fractional part of the

profession which attends a medical society meeting will not suffice. There must be an energetically pursued program to reach the majority of physicians in that area.

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There is no particular difficulty in securing the cooperation in a group program of those physicians who attend with regularity the meetings of the county medical society or the meetings of the smaller district societies or those who are attached to the various hospital staffs.

But there are others who never attend professional meetings of any sort. Through the organized County Medical Society and the post-graduate conferences, we secured the cooperation of seven hundred of these physicians. A letter was sent to every physician in the city, together with a Form of Agreement. This method of approach ultimately resulted in agreement with the seven hundred physicians.

It was fully recognized that this would not suffice and that it would be essential to secure the cooperation of such physicians as did not attend the medical meetings, many of whom probably never read the letter which was sent out under the joint auspices of the medical society and the Department of Health. We therefore employed a physician whom we termed our Medical Coordinator, a part-time man who each morning visited several of the physicians from whom no reply had been received, but who were in general practice.

In this way we reached the physicians who had probably not kept pace with modern trends in medicine, and those who might have been personally antagonistic to any endeavor on the part of either the County Medical Society or the Department of Health.

The medical coordinator spent half an hour with the newly-contacted physician, first discussing his experiences with the Health

If *efficiency* is your first demand of a therapeutic preparation, you will decide on AGAROL for the treatment of constipation.

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Liberal trial supply gladly sent to physicians.

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Department, the possible inroad of state medicine into his practice, the supposed interference with his patients by the public health nurse, and in general endeavoring to win his goodwill and interest. Then the coordinator would carefully explain that the one effective substitute for socialized medicine is for every physician to prepare himself and to undertake those services which otherwise would be rendered by the State.

Before he left the physician's office the Form of Agreement had been signed. In this way four hundred additional names were added to the list of cooperating physicians.

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It would be a mistake to proceed with public education without first preparing the physician in each field of endeavor. This is essential for two reasons: first, to bring up to date the physician who has not kept up with the times; and, secondly, to prepare all physicians so that they may fit themselves into the unified plan.

Before such a project is initiated, as for example the effort to secure the protection of young children and infants against diphtheria, it is essential that the medical profession should be thoroughly prepared.

In addition to explaining the administrative details of the plan, the medical coordinator arranged small neighborhood group meetings for physicians. Here the administration of toxin-antitoxin was demonstrated and the reading of the Schick test was shown on groups of children prepared for this purpose.

We admit that at the beginning of our study there were a few physicians who did not know the difference between antitoxin and toxin-antitoxin. There were many who were not familiar with the technique of the Schick test. Our first effort was therefore directed

toward the preparation of the physician.

At the very beginning there were instituted post-graduate conferences in communicable disease control. These meetings were held each year during the winter months on Wednesday mornings, from ten to eleven, in the auditorium of the Herman Kiefer Hospital, the institution in which we house our communicable diseases. These conferences have been built around the physicians' interest in clinical medicine, the differential diagnoses, the portrayal of interesting clinical cases.

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Every opportunity is seized to expand the interest in the program of preventive medicine. The Schick test was demonstrated time and time again, not only in these conferences, but in the meetings of the district societies and in small neighborhood groups arranged for certain physicians. The attendance at these post-graduate conferences has run from one hundred to three hundred doctors each week. In a single series one quarter of the membership of the medical society participated.

As the participation program expanded from diphtheria protection to periodic health examination, tuberculosis case finding, and the control and treatment of venereal diseases, each one of these subjects was carefully reviewed in the post-graduate conferences.

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Besides this approach to the medical graduate, the story of medical participation has annually been carried to senior medical students. They have had their usual hospital and communicable disease training, but in addition to this there has been presented the entire program of medical participation. Thus, when these students are graduated they at once become a part of the group program.

After the physician had been prepared collectively and individually, the campaign resolved itself into a program of health education, to teach the parent the need for protecting his child from diphtheria. Under the conditions of the program, which provided for no free immunization clinics but did provide that all the work should be done in the physician's office, the problem was to create a responsibility in the parent's mind in order that he would take or send the child to the physician's office for the prophylactic treatment.

The educational program has

been approached in two ways: first, through popular health instruction, by which we reach a population of 1,500,000; and secondly, through individual health instruction to about 25,000 persons.

Popular health instruction involves the various procedures generally employed by health departments. The radio has been used to great advantage. For several years the Health Department has been assigned a fifteen-minute period each week on two of our leading broadcasting stations. The newspapers have been generous in their support with news articles, feature stories, and editorials.

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During the first two years of the program the Health Department even purchased advertising space. This it can do without criticism, whereas considerable suspicion might be aroused in the public mind if the physicians advertised their own service. The printed and spoken word have been used in every possible manner. There have been billboard advertisements, street car and motorbus placards. Thousands of pieces of literature have been distributed through the schools and through the divisions of the Department of Health.

The church organizations have cooperated, especially in the Negro and Polish districts. Notices have been read from the pulpit, and special addresses delivered at religious and social gatherings.

Through the cooperation of the milk dealers and the Dairy and Food Council, special leaflets have been distributed to the homes of the city by the milkman. Business organizations, parent-teacher associations, and clubs of every kind have been addressed.

Under the conditions of the program, with the work being done in the physician's office, we met with only twenty per cent results. In other words, one moth-

er in five was interested to the extent that she took her child, at seven or eight months of age, to the family physician or to one of the cooperating physicians, and had the child protected against diphtheria.

Twenty per cent protection will not suffice. Our goal is to have not less than sixty per cent of the pre-school children protected and, better yet, fifty per cent of the infants, protected by the time they are one year old.

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To better the results, we employed a program of individual health instruction, one which is common to most modern health departments, but possibly has not been pursued quite as energetically elsewhere. The public health nurse has been made the contacting agent between the mother and the cooperating physician. She has been especially trained as a conversationalist, and taught to sell the story of diphtheria protection. She has made it a project in every school room, and a program for the parent-teacher associations. What is more important, she has directed her efforts primarily toward the mother when the infant attains the age of six months.

The efficiency rating for each individual nurse in the Detroit Department of Health, which has an important bearing on future advancement in position and salary, is based to some extent upon the results which the nurse is able to obtain in her diphtheria educational work. She receives a mark of merit for her accomplishment.

Individual health instruction wherein the nurse contacts the mother, for the most part in the latter's home, has increased the returns so that from sixty to eighty per cent of the children are receiving their protection treatment. The results seem to depend largely upon the intellectual background of the groups contacted.

Special house-to-house canvassing is carried on in areas in which the percentage of children protected is low. The degree of protection has been determined in all sanitary areas of the city.

A city-wide survey made during the summer of 1932, involving 250,000 families, indicated that 77 per cent of the school children, 43 per cent of the pre-school group and 25 per cent of infants between six months and one year of age had received at least one series of the immunizing agent.

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By way of summing up, what may be said in favor of the Detroit Medical Participation Plan?

First of all, so far as the medical profession is concerned, must be mentioned the restriction of the use of the free clinic. In the diphtheria prevention work it has

been possible to abandon free clinics. Detroit has had none for diphtheria immunization for more than four years. All the work has been carried on in the offices of the cooperating physicians. The percentage of children protected compares favorably with that in communities in which free clinics have been employed.

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In the past year we have accomplished diphtheria protection of 85 per cent of our school children, fifty per cent of the preschool children, and about forty per cent of infants at one year of age. However, we are not of the opinion that we have anywhere nearly reached that stage at which Health Department clinics for child welfare, prenatal and school services and the control and treatment of the venereal diseases and tuberculosis can be closed.

We would never subscribe to a program of drastic, revolutionary character. We do, however, subscribe to a program of education and evolution whereby the need for the free clinic will be largely minimized. Clinics serve a useful purpose as teaching centers and as a means of demonstrating the efficacy of control procedure. We believe that much of the service now rendered to indigents in clinics and dispensaries can gradually be transferred to the prepared physician in his own office.

Secondly, there is an advantage to the medical profession in that this is a program directed toward the maintenance of health. The Committee on the Cost of Medical Care have indicated that 98 per cent of the people are well on a given day and only 2 per cent are ill. To the medical profession there must be real satisfaction in serving those who are well and who in normal times are better able to pay the physician than when ill.

Thirdly, this program encourages and maintains the cordial, personal relationship between the physician and client. The successful practice of medicine still depends upon intimate and sympathetic contact between the physician and the patient. To endeavor to place this profession on the mechanical basis of the automotive industry would be unfortunate. To serve the individual to greatest advantage in case of illness the physician should be well acquainted with the physical and mental handicaps and attitudes of his client while in normal health.

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A fourth—and important—advantage to the medical profession is that the physician is compensated, in part at least, for the services he renders to indigents.

[*Turn the page*]

Why should not the doctor be paid as well as the lawyer? If we find ourselves without funds and caught in the toils of the law, the court appoints a lawyer and the State pays his fee. Surely the physician is entitled to similar consideration.

During the past three years the physicians of Detroit have lost $60,000 because of the reduction in the diphtheria death rate; but during these same three years they have been paid, either by parents or by the Health Department, $325,000 for their services.

In other words, preventive medicine has paid the physician more than curative medicine in the ratio of five to one.

Furthermore, since the average cost of treating a case of diphtheria is $35, whereas the average cost of prevention is $3, the parent has gained in the ratio of more than ten to one.

The advantages to the Health Department and to the public must be obvious to all. The death rate has been reduced until in Detroit the diphtheria death rate in 1932 was but one-fifth of that which obtained before the plan was put into effect.

The reduction in the cost of operating the health service has already been mentioned, as has the extension of the influence of the health agency by having a large number of health centers in physicians' offices scattered throughout the community.

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There is another very definite advantage to the Health Department which should be mentioned. The post-graduate conferences have encouraged the early diagnosis and treatment of communicable diseases. A greater percentage of cases of diphtheria and scarlet fever is being promptly reported.

During a recent outbreak of poliomyelitis the physicians were all watchful for the early signs of this disease. In fifty per cent of the cases hospitalized no def-

inite diagnosis of infantile paralysis was made.

These cases were sent into the institution and referred to the specialist at the onset of the earliest suggestive symptoms. We believe that this procedure was instrumental in reducing the mortality.

The advantages which accrue to the public under the Detroit plan may be summarized briefly as (1) reduction of needless sickness; (2) reduction in the cost of medical care; (3) assurance of adequate medical care; (4) more equitable distribution of cost, and (5) the stimulation of parental responsibility.

The Detroit Health Department carries an item annually in its budget amounting to one dollar per living birth with which to compensate physicians for service to indigents. In any community a rough estimate of the expense can thus be made by determining the number of living births.

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Some public health workers have criticized the Detroit program, declaring that the cost is excessive. We frankly admit that per child protected against diphtheria, the unit cost of the plan of medical participation is about twice that of free clinics. However, we do not for one moment feel that it is fair to charge the entire cost to diphtheria protection.

It is a charge against a program of medical participation, and there are many by-products which are worth more than the immediate objective.

We are on the eve of going on from paying for diphtheria immunization to paying our cooperating physicians for other types of preventive medical service. Furthermore, we feel that the underlying principles of our plan of medical participation are applicable to a program of curative as well as preventive medicine.

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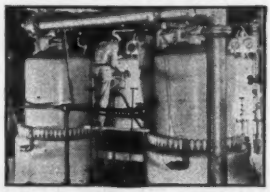

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Literature & Samples

BONE CONDUCTION FOR THE DEAFENED: Here is an opportunity for physicians to secure without charge two of the latest books on this subject. The title of the first is "Bone Conduction and Its Utilization as an Auditive Aid." This thesis, translated from the original French, comprises an accurate and exhaustive study of bone conduction. The second book, "Science's Newest Hearing Technique," gives information about the new Super-Sonotone with Lieber Oscillator, which is said to have already restored the hearing of thousands. Address the Sonotone Corporation (ME Item 12-33), 19 West 44th Street, New York, N. Y.

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TREATMENT OF PILONDIAL SINUS AND FISTULAE: This is a reprint of the paper read by Dr. Frank D. Stanton of Boston, Massachusetts, at the 1932 convention of the American College of Proctology in Chicago. For a copy, address the Post Electric Company (ME Item 12-33), 7 East 44th Street, New York, N. Y.

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A MANUAL FOR THE USE OF THE BARACH-THURSTON SOLARIUM OXYGEN TENT: A request addressed to Oxygen Therapy Service, Inc. (ME Item 12-33), 133 East 58th Street, New York, N. Y. will bring you this really valuable addition to your technical library. It is not a mere folder but a sizeable booklet, mimeographed on 8½ by 11 sheets, and consisting of 12 pages of text, 4 pages of diagrams, and 3 of photographs. Altogether, it presents a clear technical description of the oxygen tent, together with easily understood directions for assembling it and using it in oxygen therapy.

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SAMPLES OF "METAPHYLLIN" AMINOPHYLLIN: This German product, indicated for heart and vascular diseases and for water retentions (oedema, ascites) has been accepted by the American Medical Association's Council on Pharmacy and Chemistry. Samples and literature are available from Adolphe Hurst & Company, Inc. (ME Item 12-33), 330 West 42nd Street, New York, N. Y.

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WHY I INVENTED THE ROOM SILENCER: Hiram P. Maxim, famous inventor of the gun silencer and other devices, tells in this small illustrated booklet how the Maxim-Campbell Room Silencer and Air Filter was originated. Physicians who request copies from the Campbell Metal Window Corporation (ME Item 12-33), 100 East 42nd Street, New York, N. Y., should enjoy reading Mr. Maxim's discussion.

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SAMPLES OF AMINOPHYLLIN "PHARMEDIC": Council-accepted, made in the United States, this is the theophylline ethylene diamine which is soluble in cold water. It is a diuretic, vasodilator, and myocardial stimulant for use in angina pectoris, coronary sclerosis, coronary thrombosis, and cardiac insufficiency associated with edema. Samples and literature are offered to physicians only. Write the Pharmedic Corporation (ME Item 12-33), 160 East 127th Street, New York, N. Y.

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CROOKES HALIBUT LIVER OIL: This booklet reviews the advantages of halibut liver oil: freedom from unpleasant odor and taste, comparatively small dosage, lack of any tendency to nauseate. The new product, it is claimed, contains only natural vitamins A and D, two drops being equivalent to a teaspoonful of cod liver oil of 500 Vitamin A units per gram, while its natural Vitamin D content is fifteen times that of standard cod liver oil. Write Crookes Laboratories, Inc. (ME Item 12-33), 145 East 57th Street, New York, N. Y.

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HANOVIA MODEL-C KROMAYER LAMP: A folder just issued illustrates

and describes this new lamp designed specifically for the irradiation of the various body cavities with ultra-violet rays. For a copy address the Hanovia Chemical & Mfg. Co. (ME Item 12-33), 233 N. J. R. R. Ave., Newark, N. J.

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BOILO HEAD MIRROR: Perfect magnification of the subject, clear shots without distortion—these virtues the manufacturers assert in a new booklet, are assured by the accurately-ground Boilo lens. It is claimed, too, that there is no greenish tinge to the Boilo crystal lens to affect the reflected color of the tissues under examination, a consideration important in surgical and medical diagnosis. For a copy of the booklet, write the Ansell Specialty Mfg. Co., Inc. (ME Item 12-33), 39-45 Front Street, Brooklyn, N. Y.

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SAMPLES OF BREWERS' YEAST—VITAMINE TABLETS AND YEAST BOUILLON CUBES: Some more ways of taking yeast—the bouillon cubes are said to contain more Vitamine B (F&G) than a moist yeast cake, and to make a delicious broth. The yeast-vitamine tablets are claimed to be the most concentrated products of Vitamine B available. Samples are available to doctors only by writing the Harris Laboratories (ME Item 12-33), Tuckahoe, N. Y.

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THE "TRIGGER" CONTACT CAUTERY HANDLE: According to a new, illustrated folder, this device eliminates tiresome thumb pressure, remains cool at all times, and provides greater accuracy when cauterizing through specula or treating small growths. For a copy, write the National Electric Instrument Company (ME Item 12-33), 74-14 Woodside Ave., Elmhurst, L. I., N. Y.

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SAMPLES OF AMEND'S SOLUTION: Of this new product the manufacturer states in his literature, "After twenty-five years of experiment and research I have perfected a solution of iodine that may be administered internally without upsetting the stomach, causing toxic effects or producing iodism in any form." For literature and samples address the Amend Laboratories, Inc. (ME Item 12-33), 105 East 29th Street, New York, N. Y.

Postgraduate

[*Continued from page* 13]

decided to take time out of practice for that purpose in the late summer and fall of this year.

That is the season when most doctors feel a let-down in practice, and it is therefore probably the best time in the year at which to take postgraduate work. Fortunately for those who propose to journey Paris-ward for such graduate work, moreover, it is during the autumn months that the most desirable courses and the most famous professors are available.

I began last winter to plan for my six weeks' stay in Paris this summer and fall. From the Bureau des Relations Medicales avec l'Etranger, Ecole de Medicine, Salle Beclard, Paris, I obtained a complete schedule of all postgraduate courses to be given for the year 1933.

The next thing was to brush up on my French so that I could be sure of getting along fairly well with the language.

I had two years of French in high school and three years at college, plus some private tutoring. This proved sufficient to enable me to do the reading which I thought necessary to prepare myself for foreign study. Through Brentano's book store in New York City I obtained a complete obstetrical work in French, a study of which soon familiarized me with French medical terms in the particular specialty I proposed to study.

Of course reading and speaking a foreign language are two distinctly different things. For this reason I would especially recommend for the prospective visitor to Paris that he consider as a means of perfecting his pronunciation the use of some such device as Funk & Wagnall's Linguaphone, which employs a series of phonograph records.

Even if you find yourself no

linguist in any sense of the word, if French is difficult for you to learn, there is no necessity for too much worry on this score. After you get to Paris you find that, because of the close proximity of England, many of your French professors speak perfect English, and are, furthermore, most courteous to Americans, who seem to find it much more difficult to speak a foreign language than to read it. Then, too, you will find that moving pictures of surgical operations are used to a considerable extent. These will be a decided help to you.

How much does medical study in Paris cost? I can sum the whole thing up in a couple of words: *It's cheap.*

Tourist accommodations to and from France may be obtained for less than $200. I paid $99.50 a month for room and board in an excellent small hotel in Paris. If you care to live in one of the major *pensions*, you can do so for $55 a month.

Your fees for the postgraduate courses will cost you $12 to $15 each for six weeks. Hence, it is not remarkable that many of our American students are finding the medical courses in this country so expensive, by comparison with prevailing rates in France, that they are electing to go abroad for the work. Undergraduate students at the University of Paris can obtain a whole year's medical course for $42.

All French medical education is under the control of the state. Students in the University of Paris, in the University of Strassburg, and in the other medical schools of France are all required to take the same examination. Medical professors receive their aid from the government, but politics does not enter into their appointment in any way at all.

Because of the paternalistic attitude of the state toward the poorer classes, Paris presents an extraordinary quantity of clinical material. In all parts of the city large free clinics are available,

Entirely lacking in most foods...

the vitamin most needed in Pregnancy

You know the importance of vitamin D during pregnancy and lactation . . . without it the mother cannot properly absorb and utilize the calcium and phosphorus in her food—cannot adequately replace the phosphorus and calcium drawn from her own bone and tooth structure.

But do you realize the *scarcity* of this vitamin? There is no vitamin D in fruits and vegetables. Only *four* common foods contain more than a trace . . . milk, butter, eggs and fatty fish, and in the first three of these it is decidedly variable. And the body cannot long store the small amounts it may absorb from limited exposure to the summer sun.

Hence it is not enough to prescribe foods rich in phosphorus and calcium. Special provision should *also* be made for a regular supply of vitamin D.

Many doctors make such provision by prescribing three cakes of Fleischmann's Yeast daily. Now specially "irradiated," each cake has a potency of 60 Steenbock vitamin D units—the equivalent of a full teaspoonful of standard cod liver oil.

In addition, Fleischmann's Yeast is very rich in vitamins B and G, so necessary for their influence on the mother's digestion and the growth of the nursing child. And Fleischmann's Yeast is, of course, gently laxative.

Recommend 3 cakes a day, before each meal—dissolved in water, milk or fruit juice.

FOOD	VITAMIN D
VEGETABLES	
Asparagus	●
Beans, Lima	●
Beans, String	●
Beets	●
Cabbage	●
Carrots	●
Celery	●
Lettuce	●
Potatoes	●
Spinach	●
FRUITS	
Apples	●
Bananas	●
Grapefruit	●
Lemon Juice	●
Orange Juice	●
Pineapple	●
Prunes	●
MEATS AND FISH	
Meat	●
Liver	●
Fish (Average)	Trace
Fish (Fatty)	XXX
Oysters	Trace
DAIRY PRODUCTS	
Butter	X Var.
Buttermilk	●
Cheese	●
Milk	X Var.
Eggs (Yolk)	XX Var.
CEREALS	
Barley	●
Oatmeal	●
Bread (Regular)	●
Rice	●

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doctors being paid for their services in these clinics by the government. To this extent only, France may be said to have state medicine.

As I look back upon the experience, I consider not the least valuable factor of my postgraduate course in Paris the opportunity I had to mingle with medical men from various countries, excellent fellows, ambitious and earnest, with whom I exchanged ideas on medical problems. In my class there were men from Russia, Spain, Italy, the Balkan states, the South American countries, and even from Tahiti and Indo-China. There was but one other American beside myself, a chap from Connecticut. We had many a discussion together in the common language, French.

Among them, I discovered, the younger men have received the impression that American medicine is in dire straits, economically. Almost patronizingly they inquired of me and the other American if we ever hoped in this country to get out from under our burden during the present generation.

We were reminded that in France the government determines how many new doctors are needed each year; and because all medical schools are under control of the state, a close regulation of graduates is maintained, so that no oversupply of doctors exists. The current ratio is one doctor to every 1,509 people.

While the French medical schools invite American undergraduates, only one or two of them may be licensed each year to practice in France. This circumstance makes it extremely difficult for Americans to get on the staff of the American Hospital.

It is actually easier for a student who has received his medical training in the United States to obtain an interneship in France than if he had been trained in that country. I assume that the reason for this is to provide an inducement for American graduates to come to France for postgraduate work.

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The French classroom conduct is quite at variance with that of the American. The characteristic politeness of the Frenchmen pervades the lecture room, so that when the professor enters, the students formally rise, and at the end of the period give him a good round of applause by handclapping. Not to shake hands with a fellow student when greeting him in the morning and again on saying good-bye is considered a breach of social etiquette. Therefore, those of you who are considering going to Paris might just as well start to practice hand-shaking while you are working on your regular and irregular French verbs.

Don't expect a holiday. Go pre-

pared to work, and work hard. My course started with lectures at 9:30 in the morning and ended at 7:00 in the evening. And every third night I spent at the hospital.

Incidentally, the *salles de garde*, or interne's quarters of a Parisian hospital are likely to contain some of the finest "murals" to be found anywhere—things which must be seen along with the treasures of the Louvre and the Luxembourg for a complete education in French art.

Besides broadening one's general medical knowledge, a postgraduate course abroad can be made to yield real dividends in dollars, if publicized in a thoroughly ethical manner. At the end of your postgraduate course you will receive a beautifully designed certificate from the university, officially signed by the dean. This, placed in your office back home, is worth a volume of new practice to you.

If you live in a small community, the newspapers may be counted upon to consider as real news an announcement that a home town physician has received such a certificate from a distinguished foreign university.

Even before you return to this country, there is no reason why you may not begin in a modest way to publicize the fact that you are obtaining the advantage of foreign study. A picture postal

card sent home to each of your patients with a short personal note will very likely cement the bond between you, especially since these patients may be employing another physician during your absence.

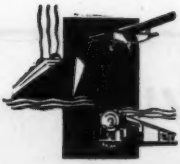
Some county medical societies do not consider it unethical for a physician to send cards to his patients announcing the reopening of his office after a course of study abroad. Just to be on the safe side, however, you had better determine from your local secretary just how your own group stands on this matter before proceeding with the sending out of such announcements.

All told, considering the fact that the lost business amounted to approximately three times the actual cost of my two months' absence from the office, the six weeks' course in Paris this year cost me quite a little. Nevertheless, I consider the money and time well spent indeed.

Within the first month since my returning to the office my work has resumed its former proportions. A number of my patients have remarked that they are quite proud to tell their friends that their doctor was abroad during the summer doing postgraduate work.

This is the sort of thing which makes me sure that, in the long run, the gain in prestige will many times repay me for my sojourn abroad.

Tours & Cruises



BARBARY LAND CRUISES: Here is an illustrated booklet explaining the highlights of several inland North African tours. It is complete in its information and description of the various trips through Algeria, Morocco and Tunisia, and offers a mode of travel that should suit every requirement—ranging from private automobiles to comfortable railroad facilities. There is something about the route itself that seems to spell vacation. Obtain a copy from the French Line (ME Item 12-33), 19 State Street, New York.

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SOUTH AMERICA: A new field for tourist travel and an unusual scenic cruise away from the beaten path is explained in a new folder bearing this title. The route is thousands of miles southward, and takes in such ports as Rio, Santos, Montevideo, and Buenos Aires. Judging from the contents of this pamphlet, the cruise would be ideal for the coming winter season. A copy will be sent any physician upon request. Write the Munson Steamship Lines (ME Item 12-33), 67 Wall Street, New York.

●

WINTER IN SWITZERLAND: For the physician or patient who is planning to spend the coming season in Switzerland to enjoy the winter sports, a 40-page booklet is offered giving complete information regarding the health resorts and hotels of the Alps. The prospective traveler will find this information invaluable in making his plans. Write the Swiss Federal Railways (ME Item 12-33), 475 Fifth Avenue, New York.

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THE FIVE HOLLANDERS: For your convenience and consideration in planning your transatlantic voyage, a book containing illustrations and descriptions of the five Holland American Line steamers is available. Full particulars concerning entertainment, meals, service and so forth are given. Drop a card to the Holland-American Line (ME Item 12-33), 29 Broadway, New York.

THE WEST INDIES: In this booklet, five expertly arranged winter cruises to the West Indies and a five-day Easter cruise to Bermuda are offered for your consideration. The Kungsholm, one of today's outstanding liners, leaves the winter behind and heads for the palm-lined shores of the West Indies. This beautifully illustrated booklet may be obtained from the Swedish-American Line (ME Item 12-33), 21 State Street, New York.

●

AROUND, ACROSS, AND OVER AMERICA: This folder will appeal to the traveler desiring to "see America first." The main feature of the circle tour it describes is the combined plane trip and ocean voyage. The coast-to-coast trip may be made by air or land at the passenger's option, and return by steamer via the Panama Canal. The steamer voyage combines restful days at sea with sightseeing calls at Havana, Panama City and Balboa. Address: Panama Pacific Line (ME Item 12-33), 1 Broadway, New York.

●

OFF THE BEATEN TRACK is the title of a guide-book which will render real service to those planning to "do Europe" in the near future. Different from most books of the kind, this one points out the smaller and more interesting places of Europe away from the customary tourist lanes and well-known hotels. You can obtain a copy and get a different slant on European travel simply by writing the International Mercantile Marine Company, (ME Item 12-33), 1 Broadway, New York.

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BOHUSLAN AND DALSLAND: These are two intriguing counties, one on the west coast, and the other in the lake district of Sweden. If you are looking for a rest in a climate noted for its clear air and temperateness, you will probably find these resorts unexcelled. A wide selection of photographs and suggestions for excursions through the surrounding country appear in a recent-

ly issued booklet which may be obtained from the Swedish State Railways (ME Item 12-33), 551 Fifth Ave., New York, N. Y.

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Anesthesia Beckons

[*Continued from page* 15]

nicians a moderate salary for administering anesthetics, collecting professional fees, and pocketing the difference as a profit to the hospital. What the majority of hospital officials do not as yet realize is that these supposed profits are more than wiped out because of the inferior anesthesia service the nurse is able to carry on, resulting directly in a length-

ened hospitalization of surgical cases.

It is commonly supposed that every patient who pays for his board, room, and service is profitable to the hospital, but this is not true. A surgical patient is profitable to the hospital only during the first week of his stay, when he is operated upon, and everybody concerned makes his fee.

It is only in hospitals run on the most economical basis that the institution can break even on the second week. And after that, the patient is a dead loss economically to the hospital. The longer the pay patient stays in the hospital, the less likelihood that his finances will hold out and that everyone who has rendered service will be equitably recompensed.

Several years ago Superintendent Bacon of the Presbyterian Hospital, Chicago, in a letter to the members of the staff, urged the speeding up of the turnover of all patients, calling attention to the fact that the saving of just one day per patient would reduce the hospital's annual overhead by $30,000.

Expert medical anesthesia is one of the few things that can decrease the patient's stay in the hospital. It saves many hospital days in the turnover of surgical patients, whereas technician anesthesia may be fairly held accountable for most of the delay in recoveries.

In a survey of surgical patients in their own hospital and in another hospital using nursing anesthesia, Drs. Russell, Connell, and Anderson, of Des Moines, Iowa, reported to their county society a saving of one and one-half days for their patients from the time they left the operating table until they took their first nourishment, adding that this saving of hospital days was anywhere from four to ten days.

Dr. F. P. DeCaux of the North Middlesex Hospital, London, an institution of 2,000 beds, by the introduction of professional gas

oxygen anesthesia has in the last five years reduced the average stay of the surgical patient from thirty to eighteen days. Another striking example may be noted at the University of California Hospital, where, under the expert professional gas oxygen anesthesia of Dr. Mary Kavanagh, the hospital stay of the goiter patients of Drs. Terry and Searls, surgeons, has been cut down from the usual two or three weeks to six days for the average and eight days for the complicated substernal cases.

But the saving of human life is, of course, more important than the saving of hospital days and dollars, and here, too, it is amply demonstrated that nursing anesthesia suffers quite as badly by comparison with expert professional anesthesia.

Dr. Frank Bortone, of Jersey City, N. J., found in a survey of New Jersey hospitals that technician anesthesia was at least one-third more fatal than professional anesthesia. Medical anesthetists have been able in some instances to reduce what had seemed like an irreduceable surgical mortality in their institutions.

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Thus Dr. Charles E. Chambers of the Rotherham Hospital, Doncaster, England, by the introduction of expert medical anesthesia and the almost exclusive use of gas oxygen, was able in a four-year period to reduce a standing surgical mortality of over 4 per cent to a little over 1 per cent. This reduction applied to all types of cases. Except for the employment of expert medical anesthesia instead of inexpert anesthesia, there was no change in the operative handling of the patient.

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At the recent Congress of Anesthetists held in Chicago, Dr. Andre Crotti of Columbus, Ohio, reported a death-rate of 0.9 per cent in a series of 7,000 goiter cases done under expert medical gas oxygen anesthesia. Dr. Frank Lahey, of Boston, reported to the Interstate Post-Graduate Assembly at Cleveland only a few weeks ago a series of over 12,000 goiter operations, done almost exclusively under expert medical gas oxygen anesthesia, with a death rate of 0.85 per cent.

The importance of the anesthetist's function is heightened by the custom in recent years of leaving the family physician and the internist on the doorstep of the hospital. He has had to step into the breach. I contend that no surgeon can properly handle the medical phases of the surgical patient and direct the administering of anesthesia by a technician at the same time he is operating.

Before the operation every resource of medical science must be brought to bear to determine the type of risk the patient represents, and to make him a better risk. Is the patient a good risk, a fair risk, or a bad risk, and what can be done to make him a good risk, if he isn't already one?

[*Turn the page*]

These are questions that only the qualified medical anesthetist can answer, thanks to an understanding of the whole field of up-to-the-minute medical practice and a thorough mastery of his own specialty.

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In its world-wide, safety-first campaign to prevent needless deaths, the International Anesthesia Research Society urges all medical specialists in anesthesia to determine the risk of their patients before operation, and to use every resource of medical science to prepare them for the ordeal. They are urged to record the ebb and flow of vitality during the operation by means of five-minute blood pressure readings, which disclose the onset of shock at least twenty minutes earlier than it can be detected in any other way, thus affording a precious interval which may be utilized to save the life of the patient who is going bad under the operation.

Shock allowed to go on unnoticed over this interval largely accounts for the deaths which occur within the first 72 hours after operation. Many a surgical case owes his life to the competent vigilance of some medical anesthetist.

The nurse anesthetist is not competent to act in the capacity of medical consultant before operation. Nor during the operation can she do the sort of charting which will keep the surgeon informed of the patient's condition and anticipate complications so that they may be met in time.

The public and the hospitals are entitled to a complete anesthesia service. It is my earnest conviction that the only person who can adequately measure up to the constantly increasing complexity of this specialty and the demands of surgery is the most highly trained type of expert medical anesthetist that can be produced.

As I see it, we need three sorts of members of the medical profes-

sion for the satisfactory conquest of human pain.

First, every doctor should know enough to be able to relieve pain associated with disease, accidental injury, minor surgery, and childbirth.

Second, there should be a group of more highly-trained medical specialists to take charge of the departments of anesthesia in the hospitals capable of rendering a complete anesthesia service.

Third, there should be expert medical anesthetists in the medical schools and teaching hospitals of the same high caliber as any other members of the faculty and staff—not only to be in charge of the anesthesia service and the teaching, but also to serve as liaison officers between the research laboratories and the operating room.

Even members of the first group can find the science of the relief from pain of great importance, if only because so many of their patients require it.

Anesthesia has become one of the broadest specialties in the practice of medicine for the reason that it no longer deals only with the problems of surgical patients. Its scope is gradually being enlarged to include the entire field of relief of pain, and also the use of anesthetics and gases for therapeutic purposes. We might instance gas therapy in pneumonia, heart, and kidney diseases, asthma, and so forth, also its use in the relief of intractable pain in chronic diseases.

In short, anesthetics and gases present to us one of the really challenging new chapters in medical practice.

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What is the future of anesthesia as a specialty? Year by year more and more men are coming into it. Anesthesia is still in the pioneer stage of its development, but will undoubtedly become a specialty of the highest importance. Its growth is world-wide, but nowhere else has medical an-

esthesia service been so remarkably developed at the present time as in the British Empire, in which every medical school and hospital has an adequate staff of from three to ten expert medical anesthetists.

The specialist in anesthesia has an economic opportunity about on a par with that of any other specialist, except perhaps the major surgeon and the eye-ear-nose-and-throat man. Incomes vary from $5,000 to $25,000, averaging between $8,000 and $10,000. Though his fees are modest, remember that the anesthetist works with the patients of a considerable number of surgeons, usually.

Aside from the financial aspects of practice, there is this to be said of the specialty: No other offers a closer liaison with the basic science research laboratories. Accordingly, the anesthetist with a leaning towards research can find an opportunity to follow his inclination.

We have now about 1,200 doctors who are specialists in anesthesia—a number that could be much more than doubled without in any way crowding the field, for the demand for qualified professional anesthetists is definitely on the increase.

Already it is not uncommon to find in the larger teaching hospitals a staff of three to five medical anesthetists. And in the General Hospital of Toronto, Canada, (typical of the British Empire's evaluation of the professional anesthetist) you will find a staff of ten.

Steadily the path to the specialty is being smoothed and broadened. All the fundamentals of anesthesia can be taught in the existing departments of our medical schools, provided they are organized accordingly. Basic science laboratories in which animals are continually being put to sleep for operations, can give instruction in all the basic principles of anesthesia. This is, in fact, being done at such universities as Wisconsin, Stanford, Cincinnati, Chicago, Illinois, and many others.

The diagnosis and medical therapy in relation to complicating diseases can readily be taught in the course on medicine. The technical application of anesthesia is taught in the department of anesthesia itself, and demonstrated in connection with all the surgical specialties and obstetrics.

When some six or seven years ago Dr. Ralph M. Waters was called to the University of Wisconsin to establish a professional

department of anesthesia, he found three nurses in charge. During his first few months he demonstrated to the staff and faculty just what they might expect of medical anesthesia instead of technician anesthesia. Then he was allowed to use the salary of one of the nurses for a fellowship in anesthesia. Within a year the salaries of the other two were likewise made available for two additional residencies in anesthesia. Thus the department was built up. In its brief existence it has thus far turned out about a dozen specialists in anesthesia.

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At Wisconsin the senior medical students get one month in anesthesia as anesthesia clerks. During their interneship they get three months in anesthesia, with the privilege, if they are so inclined, of trading for other three-month periods with other students. The two yearly residencies at $1,200 to $1,800 and the associateship at $2,400 provide direct entree to the specialty for a few.

What is happening at Wisconsin is happening elsewhere. Right now nursing anesthesia is being replaced by professional anesthesia at the Philadelphia General Hospital, under Dr. Henry Ruth.

At present we have to take men from practice and send them back to the limited available residencies. When the day comes when all the better-known medical schools shall have established departments of anesthesia similar to those at the institutions named, thus giving the younger men a chance to take up the specialty, our one big problem will be solved.

All we ask of the universities is to make available for the development of medical specialists the same amount of money at present paid out to their technicians. And we of the specialty predict that in due time in the country at large technician anesthesia will be practically a thing of the past.

Nativity

[*Continued from page* 12]

drowsiness long enough to speak to the wakeful young Rhodes.

"You had a hard day ridin' trail today, Doctor," she said. "Now you just go into the comp'ny room and take yourself a cat-nap. Do you good. We'll call you when we need you."

Grateful for the suggestion, he waited for a few minutes' more urging from Mrs. Yates and her companions before gracefully acceding to their insistence, and then went into the guest room.

The room was neat and spotless. The wide bed, with poetry embroidered on the pillow shams, looked comfortable and inviting. On one snowy sham he read, "I slept and dreamed that life was beauty," and on the other, "I waked and found that life is duty."

Hal lay across the bed with his clothes on, smiling at the reminiscences aroused by the sight of the embroidered pillow shams. He had seen shams first on a visit to the country when he was a little fellow.

The embroidered sentiments, too, were familiar. He'd run across them somewhere in his reading. Life . . . . beauty. Life . . . . duty. Joan . . . . and tonight's task . . . . Wonder if this mountain woman, embroidering those lines, was caught in their spell, too?

Somehow, ever since he had first read them, they had exercised a strong influence on him.

[*Turn the page*]

Over and over again, even at school in the lecture room, in the laboratory, or the dissecting room, when he should not have allowed his mind to wander, he had found himself mulling over those lines.

And this as yet unborn little one—what about him? What would the fates decree that he should ever know of beauty and duty? Even now, unborn, he knows as much about the life he is soon to enter upon as we do about the next . . . . The beauty and the duty . . . . beauty and . . . . he slipped over the brink of unconsciousness.

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He was waked after a while by the renewed chatter of the assembled old grannies. They had been at such places many times before. As they dipped snuff and bided the time, each in her turn boasted in vivid detail that in her own first confinement, she had had a harder time than anyone else.

In his half-waking, half-sleeping state Hal found his thoughts rambling. What if, after all, this patient were to be one of the three percent abnormals? His imagination ran wild. He thought of every possibility with a mind full of dark forebodings.

Again he heard the old gabberers turning to a favorite theme: his smallness of stature, his apparent youth. "Just a boy —don't look like he's old enough to be no doctor!" was the consensus of the old wives' opinions.

That woke him fully, like a dash of ice-cold water. Inaudibly but fervently he sent forth a prayer. God grant me success in seeing this young mother and babe safely through the dark valley!

And then he smiled again to himself. What did these garrulous old women know of modern antiseptic technique? After all, he, Hal Rhodes, was the medical authority for twenty square miles. What if something did go wrong? He could dispatch the hus-

band on horseback to the nearest telephone and a physician could be summoned to his aid from Hopkinsburg. Anyway, weren't the chances ninety-seven to three in his favor? Why worry?

This was the first chance he had ever had to be a doctor, to do the things he had all his life wanted to do, to relieve pain, to talk with the suffering, and ease them off when they had to go; to assist the Creator when life begins.

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His eyes, now accustomed to the rather faint candlelight, began to take in details of the room formerly missed.

Above the bed he noticed a large framed photograph—a family group. Going closer, he blinked in surprise at the revelation of what it actually was. Yes, it was a family group, all right, father and all. But the father lay stiff in his coffin, propped upright against a carpenter's horse, and around the coffin stood the numerous members of his family.

Ugh! What a disagreeable notion in family photography! To think he'd been trying to sleep immediately underneath that grotesque thing! He left the room abruptly.

Pulling himself together with an effort, he rejoined the group and took his chair by the fireside in apparent complacency. A glance at his watch told him he had been out a little more than an hour, though it seemed an age.

"How is the patient? Have you slept?"

"Yes, she's still a restin'. Hain't had a pain to speak of," said old Mrs. Ledbetter.

A faint glow was now beginning to appear in the east. This night of suspense would soon be over. The quiet was suddenly broken.

There came a heavy knock at the door. The front door was unbarred and Grandma from over the mountains bustled in. The

old lady, amply overweight in her own right and bundled to the ears to keep warm, had ridden the side-saddle all night in order to be with her Zilphy at this hour. Zilphy was her own namesake, the one most like her mother, of all the six daughters, and the one best loved.

"Has Zilphy got two doctors? If she ain't, you better git 'em, and git 'em quick. It allus took two doctors fer me." The old woman kept up a constant stream of chatter. Her poor Zilphy! Her first one! Why hadn't she come home to her mother to have it? Her huge frame shook as she wept mingled tears of joy and fear for her Zilphy.

And in the midst of all this hubbub, while tongues babbled greetings, while all asked questions at once and none had time to answer, dawn and the new life stole quietly into the cabin.

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Hal felt the thrill of his life when the wee one, his first delivery, set up a lusty yell which meant that the night's ordeal was over, and that he had successfully ushered into the world another life.

"Oh, now! Hain't hit jest like hit's Paw!" "No, hit's got hit's Maw's nose and mouth!" Everybody exclaimed at once.

Grandma shed tears of joy that the child was "birthed and normal." Extra joy there was too, because the first un' Zilphy birthed was a boy. She, herself, had birthed six children, but they had all been girls. Holding both hands to the fire, she rubbed off the frostiness of her long night over the mountains and crooned happily.

"No, hit hain't marked none. Hit's jest a perfect man-child, if they ever was one."

After each old lady had fondled and exclaimed to her heart's content, the babe was placed in its mother's arms. Then the all-important matter of a name arose.

"Now-a-days," began Mrs. Led-

better, "they say that some of these here up-to-date couples, like Louise and Will Crews, has names already picked out before they even git married, fer as many boys and gals as them aim to have. But in their case, they've already had more children than they had names for, and all was boys except one. Louise had nice story book names for two boys and two gals."

"Hit don't allus work out the way hit's calculated to," Mrs. Yates added, "Now, I allus named mine jest as they come. They hain't no better place to get names than out of the Bible. Course, some folks don't read hit enough these days to know all them perty names is thar. Then, too, a name has a heap to do with the way a child turns out. If he's got a good name, he'll most generally make a good man. Fer instance, I ain't never knowed nobody named Zeke that was worth a trollup."

Mrs. Guthrie, looking like a beanbag tied in the middle, said, "I'm one that don't think names is got much to do with it, so I allus told Paw it was enough for me to have 'em. He'd have to do the namin' ".

"Law me!" put in quiet little Mrs. Bibbs, who had up to this point remained in the background, "I don't aim to appear like I want this child named for any of hit's kinfolks, but I think a body ought to sort of use they's forebears as patterns, and git names for 'em. Now, when my Elmira was born I named her after little Grandmaw Gyarner who was knowed all over this country for the way she could play the melodian and sing. And long afore that child could even talk, she could carry a tune!

"If the name is such a determining factor," Hal commented, smiling, "why not give the child a break? Why not call him George Washington, or Andrew Jackson, or even Woodrow Wilson?"

Thrilled over their first born, the young parents had heretofore taken no part in the discussion. Now, with eyes full of gratitude, Mrs. Hendrickson looked towards the young doctor-by-courtesy, and placing a gentle hand on her husband's arm, she said, "Aurelius and me was just talkin' the matter over to ourselves. I want to name him for both the finest men in the world. He's named a'ready —Hal Aurelius Hendrickson, for his doctor and his Paw."

[*Turn the page*]

On his way back to town Hal reflected that this was his first Christmas in practice, his first delivery, and his first namesake. Gosh! Three great milestones reached in one night!

On this Christmas Eve he had drunk more deeply from the fountain of life than some do in three score years and ten. Certainly he was to be a great doctor, no more misgivings about that. Something new inside had been awakened, something that had all his life been pent up now felt free.

He thought he had never seen the sun so bright, nor the world more beautiful than on this Christmas morning.

Back at the club house and back to earth again, he thought once more of the girl in the city, and sent her this telegram:

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MERRY CHRISTMAS STOP
LOVE HAL

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